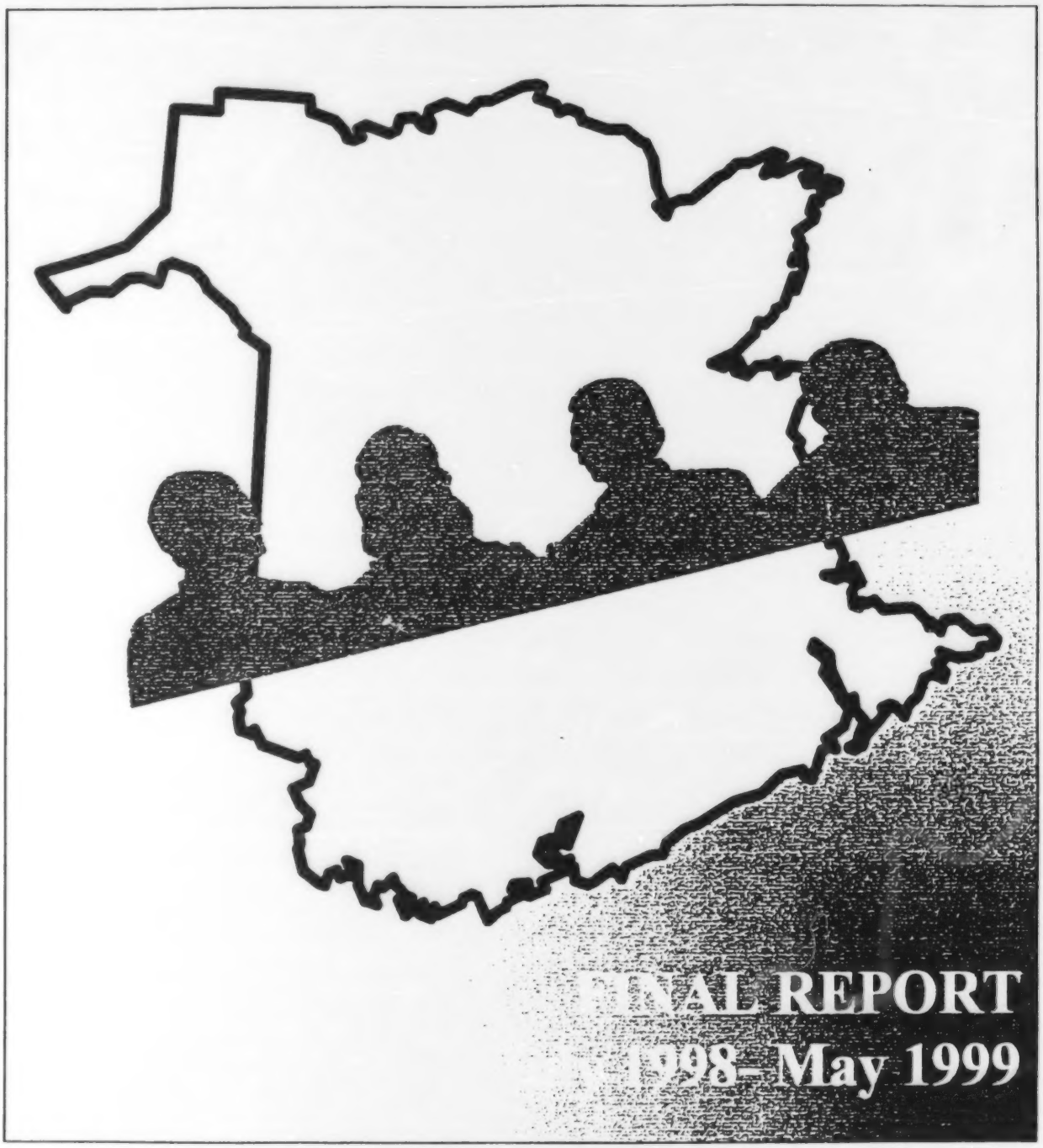
ANONYMOUS HIV TESTING PILOT PROJECT



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June 21, 1999

101-06098/

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i EXECUTIVE SUMMARY

It is estimated that 30%-40% of Canadians infected with HIV have not been diagnosed and are unaware of their infection. A deterrent to HIV testing for some individuals is the fear that test results will not remain confidential. Anonymous HIV Testing has been recommended as a necessary HIV prevention initiative and has been found to encourage HIV testing, particularly among individuals with risk factors who avoid testing under nominal or non-nominal systems. Prevention of HIV is an important and cost-effective strategy, given that the HIV epidemic remains largely in front of us, and that the lifetime costs of treating one person with HIV infection exceed $150,000.

The New Brunswick Department of Health and Community Services made a commitment to implement a one-year pilot project on Anonymous HIV Testing and base future directions on the evaluation of the pilot. The present report provides provincial evaluation profile based on data collected to May 31, 1999. It includes information about clients, services, communications, outreach, partnership development, and outlines a numbers of issues and recommendations for further consideration.

Anonymous HIV testing was launched July 20, 1998 across sites in all seven health regions. The intended clients for the service are individuals with risk factors for HIV infection who might avoid being tested because of fears about confidentiality. The pilot project objectives are to:

- Reduce risk behaviours for HIV transmission through information and counselling;
- Facilitate early detection and access to treatment for individuals infected with HIV;
- Build partnerships to enhance effectiveness in minimising HIV incidence and morbidity.

The data gathered over the first 10 months shows the service to be in accord with the recommendations of the Health Services Review Committee and an important health promotion and disease prevention initiative in populations at particular risk of infection. The findings provide solid empirical support for continuing the service and converting the anonymous HIV testing pilot project to a regular Public Health program. By the end of May 1999:

- 380 clients, with a range of risk factors for HIV, received pre-test and post-test services, including education and counselling related to the reduction of risk behaviours that transmit HIV and other communicable diseases;
- 43% of clients were under 25 years of age, an age category with a high rate of risk factors, where prevention efforts can be particularly important;
- more than one-third of males tested were men who have sex with men; 84% had chosen anonymous HIV testing over other testing options and a majority had previously avoided HIV testing;
- a number of clients reported high risk activities, such as intravenous drug use or unprotected sex with an HIV positive individual, intravenous drug user, man-having-sex-with-men, or very large number of partners;
- 77% of all clients chose anonymous HIV testing over nominal or non-nominal approaches, almost all because of anonymity concerns;

- the majority of clients had avoided HIV testing previously because of anonymity concerns;
- most clients reported having decreased their HIV related risk behaviours in the period between pre- and post-test counselling, and most intended to reduce HIV related risk behaviours in the future.

While no new HIV infections have yet been identified through the pilot, regional public health teams and other key stakeholders strongly support the continuation of the service. Great strides have been made in reaching some of New Brunswick's vulnerable populations, and in providing necessary groundwork for future initiatives involving the complex factors rendering individuals at risk for HIV and other communicable diseases. The report outlines a number of issues and recommendations for building on the momentum established over the first 10 months toward effectively reaching the New Brunswickers who are HIV-infected but still unaware of their status. These include:

(1) Holding a provincial meeting of Anonymous HIV Testing team members and provincial stakeholders;
(2) Continuing and enhancing regional partnership development and outreach initiatives;
(3) Exploring the feasibility of concurrent testing for other infections associated with similar risk factors as HIV (e.g., hepatitis);
(4) Increasing collaboration with First Nation communities;
(5) Exploring the possibilities of providing anonymous HIV testing within correctional facilities;
(6) Investigating issues around prenatal HIV testing; and
(7) Proceeding with the evaluation strategy.

1.0 INTRODUCTION

1.1 Purpose of this Report

The Department of Health and Community Services made a public commitment to implement a one-year pilot project on Anonymous HIV Testing and base future directions on the evaluation of the pilot. The Anonymous HIV Testing Pilot Project began July 20, 1998 and testing sites in all seven health regions became operational at that time or soon thereafter. The main purpose of this report is to provide the Department with the necessary evaluation data on which to base decisions related to the future of anonymous HIV testing in New Brunswick. It provides a provincial profile based on data collected to May 31, 1999. Information on clientele, services, communications, outreach, and partnership development is included, as are a number of issues and recommendations for further consideration.

An Interim Report (February 26, 1999) based on the first five months of the Anonymous HIV Testing service provided initial support pertaining to the merits of the initiative, particularly in terms of health promotion and disease prevention among New Brunswick's vulnerable populations. The present report builds on the earlier midcourse assessment by providing a status update and evaluation of the first 10 months of the project. While the pilot is slated to extend to July 20, 1999, completing the evaluation after the full year pilot phase could result in a 2-3 month gap in service delivery while awaiting a decision regarding program continuity. The process of discontinuation-reinstitution would not only be disruptive and inefficient for clients, staff, management, and other partner organizations, it would also result in public confusion and additional communication costs.

Significant accomplishments have occurred in all regions in developing and implementing this service, and laying a foundation for further progress on HIV prevention. The service is clearly effective in meeting both client needs and pilot objectives related to prevention. The information provided to date also raises some issues for further consideration at provincial and regional levels. These are noted, with draft recommendations for addressing them.

1.2 Rationale for Anonymous HIV Testing

1.2.1 **Overview.** Despite major advances in the treatment of HIV infection, the HIV epidemic in Canada remains largely in front of us, and the incidence of new reported HIV infections has risen by 33 percent since the early 1990's (Remis, 1997). Furthermore, it is estimated that 30%-40% of all individuals infected with HIV in Canada are unaware of their HIV infection (Laboratory Centre for Disease Control, 1999b). Canadian epidemiological reports indicate that HIV is spreading most rapidly among drug users, young gay men, Aboriginal populations, prisoners, and women (Laboratory Centre for Disease Control, 1998). Studies conducted in New Brunswick also point to the need for encouraging testing and prevention among such populations (Getty et al., 1999; Getty et al., 1997; Myers et al., 1993; Ploem, 1996).

HIV prevention remains a critical public health objective and a major goal of the *Canadian Strategy on HIV/AIDS* (Health Canada, 1998). In addition to the significant human costs associated with HIV/AIDS, there are powerful economic incentives to preventing the spread of HIV. According to a recent report commissioned by Health Canada, the lifetime costs of treating one person with HIV infection exceed $150,000. This does not include the many other direct and indirect costs to government and society, such as lost productivity (Albert & Williams, 1998). Education and counselling about risk behaviours and how to avoid infection, combined with early detection of infections through timely testing are therefore important components of an HIV/AIDS strategy.

Early diagnosis of HIV infection has major advantages. Morbidity associated with HIV infection can be considerably decreased when treatment is started early. Individuals who are aware of their infection can take steps to prevent transmission to others, rather than unknowingly passing on the virus. In HIV-positive pregnant women, maternal-infant transmission can be reduced by approximately two-thirds if drug treatment is started early in the course of pregnancy and a caesarean section delivery can reduce infection rates in infants.

Despite the advantages of testing and early diagnosis, up to 40% of infected Canadians have not been diagnosed and may be engaging in behaviours resulting in HIV transmission to others (Laboratory Centre for Disease Control, 1999b). A deterrent to HIV testing among some individuals is the fear that testing or test results will not remain confidential (Hirano et al., 1994; Hoxworth et al., 1994). Some are concerned about stigmatization and discrimination associated with HIV infection. Although HIV/AIDS education programs targetted at the general population can continue to address these issues, many situations of overt as well as covert discrimination persist (Jürgens & Palles, 1997). Other individuals may be reluctant to disclose their involvement with risks such as intravenous drug use, contacts with sex trade workers or other unprotected sexual activity (e.g. extramarital, men having sex with men), and they may initially fear accessing health services where records could link them to these activities.

Research has found that barriers to testing can be reduced by including anonymous HIV testing in the service continuum. Anonymous HIV testing has been recognized for more than a decade by experts internationally, nationally and provincially as an important preventive and diagnostic option for some individuals with risk factors who avoid other modes of testing. Effective, client-centred services for anonymous HIV testing can provide a safe entry point for individuals with risk factors for HIV to take steps to assess and deal with issues in their lives related to HIV transmission and infection.

All provinces and territories except Manitoba, Prince Edward Island, the Northwest Territories and the Yukon offer anonymous HIV Testing (Laboratory Centre for Disease Control, 1999a). Although anonymous HIV tests are usually a small proportion of total HIV tests in jurisdictions where it is available, the option of anonymous HIV testing is regarded as an important component to reach populations at particular risk of infection. The evidence in this regard has been strengthened since New Brunswick began its pilot (Bindman et al., 1998; Centers for Disease Control, 1998; Centers for Disease Control, 1999a; Nakashima et al., 1998)

In sum, anonymous testing:

- Attracts a greater proportion of individuals at particularly high risk for HIV infection (e.g., men who have sex with men) than nominal or non-nominal testing.
- Encourages testing among individuals with risk factors who have avoided testing out of fear that testing or test results will not remain confidential.
- Attracts a greater proportion of HIV-positive clients than programs that do not provide reassurance around anonymity.
- Can facilitate earlier diagnosis and access to care.
- Allows for excellent return rates and partner notification. The vast majority (more than 90%) of persons who undertake anonymous HIV testing return to learn their test results (Fehrs et al., 1988; Ontario Ministry of Health, 1994). As in nominal and non-nominal systems, partner notification depends primarily on client cooperation in identifying and contacting partners.

1.2.2 The New Brunswick Context. Provincial Epidemiology Service figures show 13 new HIV infections and 4 new cases of AIDS were reported in New Brunswick in 1998. New HIV cases were reported among both men (9) and women (4). Reported risk factors included men having sex with men (6), heterosexual sex (4), and intravenous drug use (2). HIV detection in individuals between 20-29 years (3) suggests infection may have occurred during the teenage years in at least some of these individuals. No new infections were reported in pregnant women or infants. The fact that 3 additional cases were reported only after they had reached the stage of AIDS highlights the importance of continuing efforts aimed at earlier detection.

Table 1.1 shows the stated region of residence for the 60 individuals newly diagnosed with HIV in New Brunswick in 1994-1998. The three regions with the larger populations had more reported cases, although all regions had at least one reported case. The AIDS clinic in Moncton may have a bearing on the higher total for Region 1.

Table 1.1

HIV Cases First Diagnosed in New Brunswick (1994-1998* inclusive)								
	Health Region							
	1	2	3	4	5	6	7	Total
# of HIV cases	25	13	13	1	2	2	4	60
* Data for 1998 is provisional.								

There are reports of 9 HIV positive inmates and one living with AIDS in federal correctional facilities in New Brunswick in January 1999 (i.e. prevalence, not new cases). Comparable data is not currently available for provincial correction facilities.

Although New Brunswick rates of known HIV infection have been low in comparison with some other geographic areas in the country, complacency would be ill-advised. As noted below, risk factors and vulnerable populations are present, and in some cases increasing. Furthermore, as noted by Kahn (1996), "The best practice model shows that for high-risk populations, the number of infections prevented is maximized when prevention is targetted early or at a time of low HIV prevalence in the population in question."

- New Brunswick has not been exempt from the shifts occurring in the rest of the country in the routes of transmission and population groups affected. For example, the 1996 New Brunswick seroprevalence survey of all pregnant women found that four were positive for HIV (Getty et al., 1996).

- Surveys and other information indicate that intravenous drug use and other practices with the potential to transmit HIV (e.g., steroid injections, tattooing) are occurring in New Brunswick (Department of Health and Community Services, 1998; Ploem, 1996).

- Information from the 1996 Student Drug Use Survey in New Brunswick indicates that a high proportion of high school students engage in unprotected sexual activity with multiple partners, and that some students are engaging in drug use patterns which could put them at risk for HIV.

- Within the last two years, the use of crack cocaine has increased dramatically in two of New Brunswick's largest cities. While Saint John has been particularly hard hit, the incidence in Fredericton has also been on the rise (Appleby, February 1, 1999). This is a cause for concern, given that the rapid spread of HIV infection among Vancouver's injection drug users was associated with a shift from heroin to crack cocaine as the drug of choice (Albert & Williams, 1998). Rather than injecting once a day, crack users may inject many times daily to feed their addictions.

- New Brunswick is not immune to a variety of other factors associated with vulnerability to HIV-infection: e.g., homelessness, addictions, illiteracy, sexual abuse, and poverty.

2.0 DESIGN OF ANONYMOUS HIV TESTING PILOT PROJECT

2.1 Overall Purpose and Approach to the Pilot

The pilot project is aimed at the Departmental goals of minimizing HIV incidence and HIV-associated morbidity. Its objectives are to:

- Reduce risk behaviours for HIV transmission through information and counselling;
- Facilitate early detection and access to treatment for individuals infected with HIV; and
- Build partnerships to enhance effectiveness in minimizing HIV incidence and morbidity.

It is acknowledged that anonymous HIV testing is only one component of preventing the transmission of HIV infection and that social and economic marginalization, as well as a variety of other complex factors are contributing to the increasing incidence of HIV among vulnerable populations (i.e., health determinants approach).

Since most vulnerable populations are difficult to reach and challenge traditional methods of HIV prevention, initiating and/or strengthening relationships with a variety of intersectoral (e.g., education, corrections, Aboriginal populations, community-based services) as well as health partners is viewed as instrumental in reaching those at risk for HIV.

2.2 Background

In 1997, a Ministerial commitment to implement a one-year anonymous HIV testing pilot project was announced. This commitment had been preceded by advocacy efforts by AIDS New Brunswick and other community groups, as well as analysis by Departmental staff.

To prepare for implementation, the requirements for delivering a quality anonymous HIV service were identified, based on best practice literature and consultation with jurisdictions that have provided and evaluated such services for years (Ontario, Nova Scotia, Saskatchewan, Maine). In addition, various options were outlined for providing this service in New Brunswick. The planning process was led by a Project Manager, Public Health Management Service and a Project Coordinator, hired on contract. Consultation during this process involved Public Health Medical Officers of Health/Regional Directors and Sexual Health Centre staff, other departmental representatives (Provincial Epidemiology Service, Program Analysis and Evaluation, Hospital and Laboratory Services, Medicare, Communications), professional associations (New Brunswick Medical Society, Nurses Association of New Brunswick), community-based organizations (e.g. AIDS Service Organizations), and other stakeholders (HIV/AIDS Clinics).

After considering various options for providing anonymous HIV testing, the Public Health Management Committee made a decision to establish pilot sites in Sexual Health Centres in the seven health regions, on the basis that necessary additional resources would be available. Teams, comprising a Regional Team Manager, Public Health Nurse (plus backup), Administrative Support Staff person and Regional Administrative Coordinator were established in each region to develop the regional plans and budget for the pilot project. Additional funding for regions to implement the pilot was subsequently confirmed.

To support regional planning and ensure adequate provincial consistency where necessary (e.g. service quality standards, evaluation data), planning also continued at the provincial level in conjunction with regions and involving regional input. Documents developed included Guidelines for Procedures and Protocols (March 23, 1998), budget for approval by the Public Health Management Committee, laboratory requirements, communication strategy, a monitoring and evaluation plan, and data collection forms.

Team members from all regions (Regional Team Managers, Public Health Nurses, and Administrative Support Staff) participated in a two-day provincial workshop, June 18-19, 1998, to prepare for pilot implementation on July 20, 1998. At that time, all test sites began taking phone calls and booking appointments for anonymous HIV testing. The majority of sites started seeing clients shortly thereafter. A few sites delayed the onset of pre-test counselling until the completion of summer holidays or the resolution of implementation requirements. All seven sites had provided pre-test counselling by September, 1998.

2.3 Intended Clients and Services

The intended clients for New Brunswick's anonymous testing service are individuals with risk factors for HIV infection who avoid being tested because of fears about confidentiality.

The anonymous HIV testing pilot sites provide the following services to clients, consistent with guidelines for anonymous HIV testing in other Canadian jurisdictions:

- Facilitating client access on an anonymous basis (e.g., answering telephone inquiries about the testing procedures, scheduling appointments);
- Pre-test counselling;
- Collection of blood samples and arranging for their transportation to the laboratory;
- Reporting test results to clients, with post-test counselling;
- Referrals to medical and support services for individuals who test positive (not yet required since no test results have been positive to date);
- Information and referrals, if appropriate, for individuals with other risk factors (e.g. population health approach; issues such as drug addictions, sexual abuse).

2.4 Evaluation

Evaluation is an integral component of the Anonymous HIV Testing Pilot Project. A combination of process and outcome evaluation methodologies is being used to assess the project in relation to its goals, objectives and criteria. The main data sources for the project's current evaluation include:

- Counsellor Checklist: completed for all clients, including data on demographics, risk factors, services provided, and other information important to quality service provision and pilot evaluation;
- Client Feedback Form: one page form (optional) for clients to provide feedback after visits;
- Information on Outreach Initiatives: contacts, partners, activities, developments, results;
- Administrative Data: management, staffing, budget tracking;
- Key Informant Interviews/Stakeholder feedback: input from regional teams and other stakeholders, including but not limited to, those involved in the initial design. Feedback has been received from regional team members and stakeholders (e.g., AIDS NB, SIDA/AIDS Moncton, AIDS Saint John, Atlantic First Nations AIDS Task Force, and the Nurses Association of New Brunswick).

3.0 DEVELOPMENTS AND RESULTS (JULY 1998- May 1999)

3.1 Overview

Data collected from various sources indicate significant regional accomplishments in providing an accessible, quality service to individuals with HIV-related risk factors.

- 380 clients, with a range of risk factors for HIV, received pre-test and post-test services;
- 43% of clients were under 25 years of age, an age category with a high rate of risk factors, where prevention efforts can be particularly important;
- more than one-third of all male clients reported having sex with men; and 84% had chosen anonymous HIV testing over other approaches (almost all due to fears around confidentiality);
- unprotected sex with a partner known to have HIV/AIDS or at increased vulnerability for HIV (i.e., man who has sex with men, intravenous drug user, resident or native of a country where heterosexual transmission predominates, or a resident of a geographic location or prison know to have high rates of HIV) was reported in 173 instances;
- some clients also reported injection drug use (12) or having unprotected sex with a very large number of partners;
- 77% of all clients had chosen anonymous HIV testing over nominal or non-nominal approaches, almost all because of anonymity concerns;
- 41% of clients had avoided HIV testing previously because of anonymity concerns;
- 93% of clients returned for their results;
- more than one-half of all clients reported having decreased their HIV related risk behaviours in the period between pre-and post-test counselling, and approximately two-thirds intended to reduce HIV related risk behaviours in the future;
- information and referrals for additional services were provided in 536 instances;
- partnerships are being developed with many stakeholders providing services to vulnerable populations;
- Client feedback questionnaires and responses from AIDS Service Organizations and other stakeholders show a high degree of satisfaction with the service.

3.2 Communications, Outreach and Partnership Development

Canadians most at risk for HIV-infection often face many other problems – e.g., homelessness, addictions, violence, poverty and hunger, or have few contacts with the health system (e.g., youth). Building the lines of communication and trust with agencies that are experienced with, have access to, and have the ability to inform, refer and support populations at risk around HIV testing and other predisposing factors has been a main objective of the pilot project's communication and outreach strategy.

In addition, provision of this testing service can provide an entry point for individuals at risk to receive information and referrals to other services that may be of assistance to them. Those involved with this service may also become involved in catalyzing or enhancing intersectoral action to promote health or reduce harm. It can thereby serve as a vehicle for improving population health in diverse ways.

Interest in the anonymous HIV testing pilot project remains high among stakeholders, as does the demand for additional wallet cards, brochures and posters targetted to clients. While many of these materials were distributed proactively during the project's initial phase, additional requests for approximately 24,000 materials were filled in the first ten months and were forwarded to various locations, including: hospitals, addiction centres, Aboriginal communities, education facilities, AIDS organizations and correctional facilities (see Tables 3.1 and 3.2).

Table 3.1

Phase 1 & 2: Proactive Distribution of Materials on Anonymous HIV Testing (July – November/1998)	
1. General Practitioners & OB/GYN (630)	12. Sexual Assault Centres (10)
2. NB Medical institutions/health centres (53)	13. Muriel McQueen Fergusson Foundation(1)
3. Mental health centres (13)	14. Planned Parenthood Fredericton (1)
4. Sexual Health Centres (9)	15. New Brunswick Gay/Lesbian/Bisexual Bars (2)
5. Public Health Offices (28)	16. Other Bars and Pubs (290)
6. AIDS Clinics (2)	17. Gay/lesbian/bisexual organizations (8)
7. AIDS Service Organizations (4)	18. Women's shelters (12)
8. Addiction/treatment centres (8)	19. Native Friendship Centres/Reserves (17)
9. Youth Shelters/Homeless Shelters (5)	20. Department of Education High School Principals (71) Superintendents (18) Directors of Education (18) Student Services Supervisors (18)
10. John Howard Societies (5) & E. Fry (2)	21. Universities/Community Colleges (18)
11. Crisis/Help Lines (Tele-care; Chimo; etc.(5)	22. Other Federal & Provincial Government Departments and Agencies: Solicitor General, CSC
Additional Requests Filled (July 1998 – May 1999)	
Physicians	Universities/Community Colleges
Sexual Health Centres	High Schools
Hospitals	AIDS Service Organizations
Addiction Treatment Centres	Public Health Offices
Federal/Provincial/Youth Correctional Facilities	Bars

Table 3.2

Anonymous HIV Testing Totals of Materials Distributed			
	Wallet Cards	**Brochures**	**Posters**
Phase 1 & 2 (Proactive Distribution through Central Office): 07/98 – 05/99	**52,955**	**37,035**	**4,339**
Additional Requests:			
• ***July – September***	3,950	3,350	401
• ***October – December***	4,750	3,350	713
• ***January – March***	2810	1710	162
• ***April – May***	1750	900	
SUBTOTAL (Additional Requests)	**13,260**	**9,310**	**1,276**
TOTAL	**66,215**	**46,345**	**5,615**
Total Printed	75,000	50,000	7,000
Remaining for distribution (Feb-July/99)	**13,345**	**3,655**	**1,385**

The process of partnership-building and outreach is developmental in nature, and continues to evolve with the pilot project. Provincial, regional and local initiatives are summarized below.

3.2.1 **Provincial Strategies.** Dissemination of information about New Brunswick's Anonymous HIV Testing Pilot Project to provincial stakeholders was launched during the project's design phase. It remains an ongoing component of the anonymous HIV testing pilot project's implementation and is aimed at informing potential clients and appropriate service providers about various aspects of the anonymous testing pilot (e.g., available services and points of access), and encouraging testing among the pilot's target populations.

A number of partnerships and networking activities were initiated both centrally and regionally during the provincial training workshop. Key stakeholders were invited to participate in the training and preparation of the Regional Teams for Anonymous HIV Testing. Representatives of various agencies/organizations were present: AIDS New Brunswick, AIDS Saint John, SIDA AIDS Moncton, Atlantic First Nations AIDS Task Force, Child Find NB, St. Mary's Health Centre, Canadian AIDS Society, UNB Faculty of Nursing, and the Moncton Hospital HIV/AIDS Clinic. A partnership was also established with the Ontario Ministry of Health (AIDS Bureau), which played an important role in sharing information and skills based on a decade of experience with anonymous HIV testing.

Given the importance of complementing the provincial communication strategy with outreach and partnership-building activities tailored for regional needs, sessions on outreach and partnership-building activities were held during the 2-day training workshop. Invaluable knowledge and skills were shared through the participation of professionals working with or members of various vulnerable populations (e.g., men who have sex with men, injection drug users, Aboriginal populations, street youth).

Over the course of the project's first ten months, a number of different strategies have been implemented through PH Central Office, in collaboration with the Communications Branch, as well as AIDS service organizations and other groups toward reaching New Brunswick populations:

- Personal contact with key service providers (e.g., AFNATF, AIDS NB, AIDS Saint John, SIDA AIDS Moncton, Child Find, Department of the Solicitor General).
- Articles in Professional Association Newsletters (i.e., New Brunswick Medical Society, Nurses' Association of New Brunswick).
- Articles/advertisements in New Brunswick AIDS Service Organization and other agency newsletters (e.g., AIDS New Brunswick, Provincial Newsletter of NB's ASO's, Atlantic Canada's Pride Guide) and selected publications for post-secondary students.
- Toll-free AIDS Information Line operated by AIDS NB. Reports from AIDS NB indicate that they have received numerous inquiries about anonymous HIV testing, resulting in the referral of 410 clients to the service between July, 1998 and May, 1999.
- Articles/stories in mainstream media (TV, radio, newspapers).
- Print material (posters, brochures and wallet cards) targeted to client groups.
- "Newsletter" Infosheets, explaining the Anonymous Testing project (e.g., rationale, services provided, points of access, and where to get more information) were widely distributed to various administrators and front-line workers dealing with vulnerable populations (e.g., all general practitioners and obstetricians/gynecologists; all high schools, community colleges and universities). Each Infosheet was tailored to meet the informational needs of specific partners (i.e., NBMS, NANB, Corrections, Department of Education, and Universities/Colleges.
- Web sites/web links (e.g., Department of Health and Community Services, AIDS NB, Atlantic First Nations AIDS Task Force).

3.2.2 Regional Approaches. A variety of regional partnerships, serving to complement or reinforce those at the provincial level, have been initiated and/or strengthened since the launching of the pilot project. Most anonymous testing sites have been instrumental in building partnerships and initiating outreach initiatives designed to meet regional needs. Strategies have included telephone contact, in-person meetings, the development of region-specific written information, workshops/presentations, information displays, site visits, and media interviews. On-site anonymous HIV testing at Romero House, a soup kitchen in the heart of Saint John, is also available weekly through Region 2's AT Nurse.

Other particularly notable regional initiatives include, but are not limited to: Exploring the possibility of on-site testing at Ridgewood, the largest addiction treatment centre in New Brunswick (Region 2); collaborating with various local or regional polices forces to distribute information about anonymous HIV testing to vulnerable populations such as sex trade workers and injection drug users (Regions 1, 2, and 3); and exploring the possibility of on-site testing at Atlantic Institution, a federal maximum security correctional facility located in Renous (Region 7).

Intersectoral contacts or partners reported by one or more regional teams are indicated in Table 3.3. Table 3.4 provides an outline of some of the vulnerable populations specifically targetted through the aforementioned outreach and partnership-building efforts. Given differing needs, available partners, staff allocation and time for anonymous HIV testing, regional differences are evident in the level of outreach services provided to date.

Table 3.3

Intersectoral Contacts	
➢ Aboriginal/First Nations Communities	➢ Liver Foundation
➢ Addiction Services Treatment Centre	➢ Local businesses
➢ AIDS Service Organizations	➢ Mental Health Centre
➢ Bars	➢ Miscellaneous Health organizations (e.g., Comcare, Medi-Trust, Canadian Blood Services)
➢ Big Brothers/Big Sisters	➢ Native Friendship Centre
➢ Boys & Girls Club	➢ Native Women's Transition House
➢ Canadian Armed Forces	➢ Nursing homes
➢ Canadian Mental Health Association	➢ Other Community-based locations/organizations (e.g., YM/YWCA, Food Banks, Human Development Council, Learning Exchange)
➢ Child Find/Street Outreach Services	➢ Parole Offices
➢ Crisis lines	➢ Pharmacies
➢ Community Centres	➢ Police Forces (RCMP and municipal)
➢ Community Colleges	➢ Pregnancy Crisis Centres/ Planned Parenthood/Birthright
➢ Community Health Centres	➢ Prisons (federal and provincial)
➢ Correctional Service of Canada	➢ Regional and local media
➢ Domestic Violence Crisis Centres	➢ Salvation Army
➢ Elizabeth Fry Society	➢ Sexual Assault Crisis Centres
➢ Fredericton Needle Exchange Committee	➢ Soup kitchens/homeless shelters
➢ Gay Bars	➢ Transition Houses/ Women's shelters
➢ Gay/Lesbian/Bisexual Organizations	➢ Universities
➢ Government Divisions (e.g., FCSS, Mental Health, Addiction Services, HRD)	➢ Youth Correctional Facilities
➢ Governmental Departments (e.g., Education, Solicitor General)	➢ Youth Group homes
➢ Half-way house for parolees	➢ Youth Outreach Centres
➢ High Schools	➢ Youth Coalitions
➢ Hospitals	
➢ Infectious Disease Specialists and other physicians	
➢ John Howard Society	

Table 3.4

	Region						
Populations	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Addictions	✓	✓	✓	✓			✓
Aboriginal Populations	✓	*	✓	✓			✓
Prison Populations	✓	✓	✓	✓			✓
Vulnerable Youth	✓	✓	✓	✓	✓	✓	✓
Youth (high school/post-secondary)	✓	✓	✓	✓	✓	✓	✓
Street involved people/homeless	✓	✓	✓				
Sex trade workers	✓	✓					
Men who have sex with men (MSM)	✓	✓	✓			✓	✓
Vulnerable Women	✓	✓	✓	✓	✓	✓	✓
Other	✓	✓	✓	✓	✓	✓	✓
** There are no First Nation Communities/Reserves in Region 2.*							

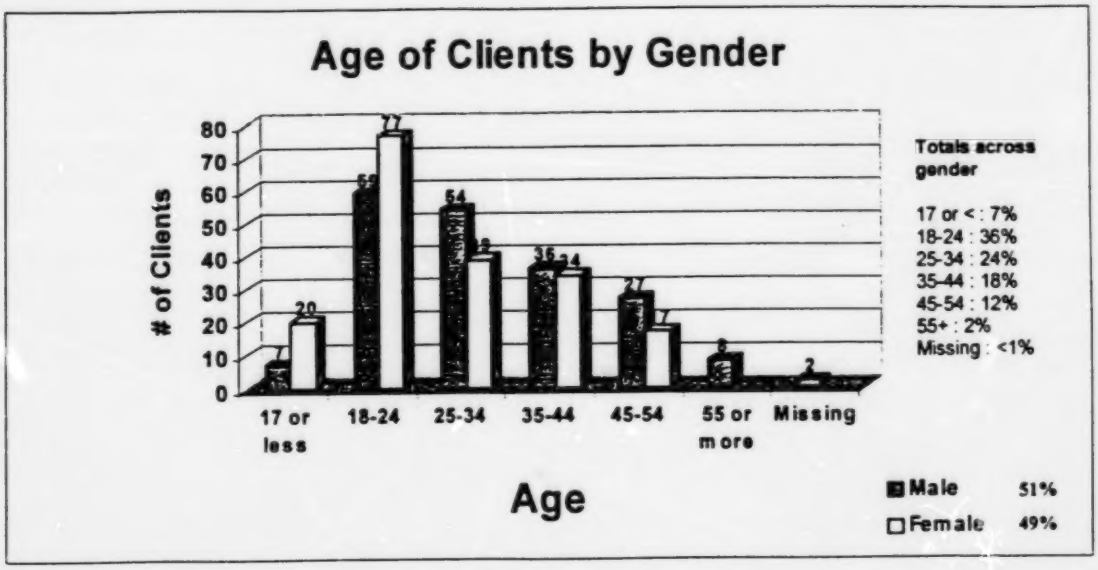
3.3 Characteristics of Clients and Services Provided

At the end of each month, regional AT sites forward Counsellor Checklists to central office for tabulation and evaluation. Counsellor Checklists are forwarded for all clients who have received post-test counselling during that month or for clients who have not returned for post-test by the time six weeks has elapsed since pre-test. Information is provided below on the 380 clients who met these criteria up to May 31, 1999. The return rate during this period was 93%, a rate exceeding and/or comparable to that found in most other jurisdictions. All of the clients who had not returned for their results within the six-week time frame had tested negative.

3.3.1 Client Characteristics

Demographic Information. During the initial ten months of the project, clients represented a cross-section of gender and ages (Figure 3.1). Of the 380 clients, 51% were male and 49% were female. Clients ranged in age from their teens to 55 years or more, with 43% under 25 years and approximately two-thirds less than 35 years of age. The most common age category was 18-24 years, indicating that the project is attracting New Brunswick youth. One woman reported being pregnant and four reported possibly being pregnant. The vast majority of clients (99%) resided in New Brunswick at the time of testing.

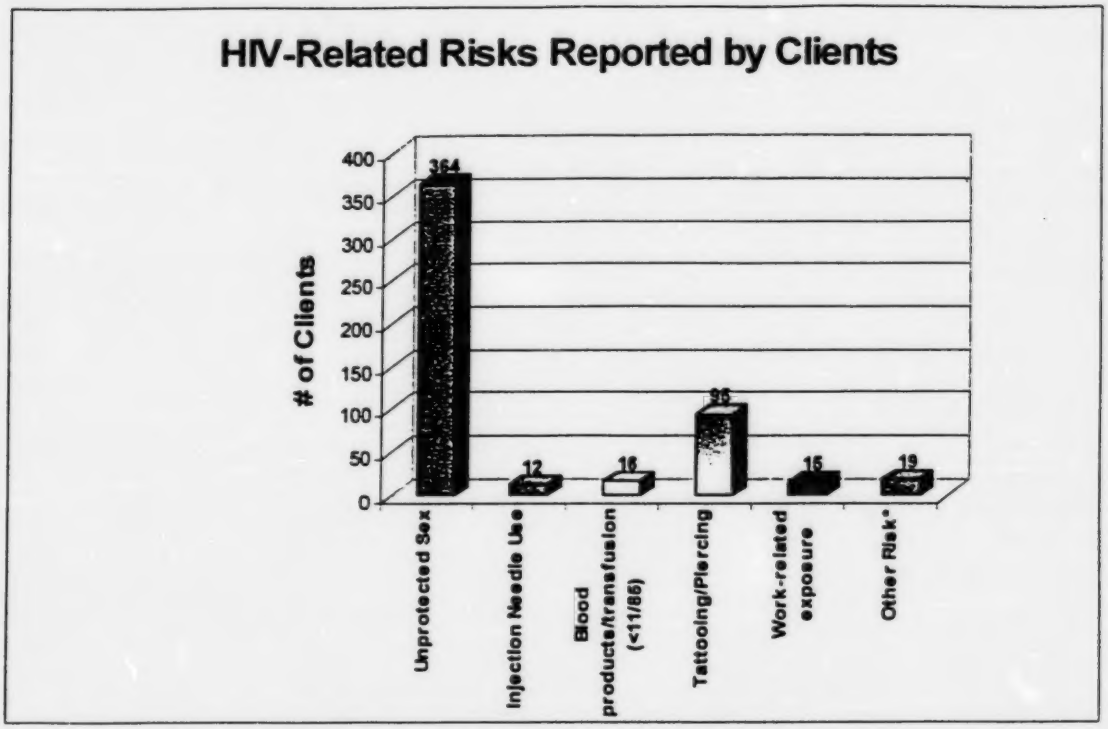
Figure 3.1



Reasons for Requesting HIV Testing. Clients were asked about their reasons for requesting HIV testing, and one or more answers were recorded on the checklist by the counsellor. Worry that past activities may have exposed them to HIV was reported by 55% of clients and wanting to confirm their negative status was reported by 40%. More than 7% of all clients indicated that their partners had requested they be tested. A total of 23 clients gave the following reasons: Known exposure to HIV (7); Notified by or about an HIV positive partner (8); and Suspect they might have HIV-related symptoms (8). Five clients wanted to be tested because of having been sexually assaulted, and eight clients reported that their partners had been unfaithful. Two clients wanted to know their HIV status because they were considering pregnancy (female) or starting a family (male). Finally, five clients reported that they had come to the AT clinic because their physician had either encouraged (3) or discouraged (2) HIV testing.

HIV-Related Risk Behaviours. During the pre-test counselling session, clients were asked about their potential exposures to HIV to assist in risk assessment and counselling. Almost all clients who were willing to disclose this personal information (367/371 or 99%) reported one or more potential risks. As shown in Figure 3.2, the most commonly cited risk factor was unprotected sexual activity, which was reported by 96% (364/380) of all clients. Unprotected vaginal intercourse was reported by 87% of all respondents, followed by oral (69%) and anal (20%) sex. Very few cited the use of uncleaned shared sex toys (1%). Additional reported potential exposures to HIV by anonymous HIV testing clients included tattooing/piercing (95), transfusion of blood or blood products prior to 1985 (16), work-related exposure (15), injection needle use (12), and other (19). The most common risks included in the "other" category included: non-occupational exposure to blood, semen/vaginal fluids on broken skin, and sexual assault.

Figure 3.2

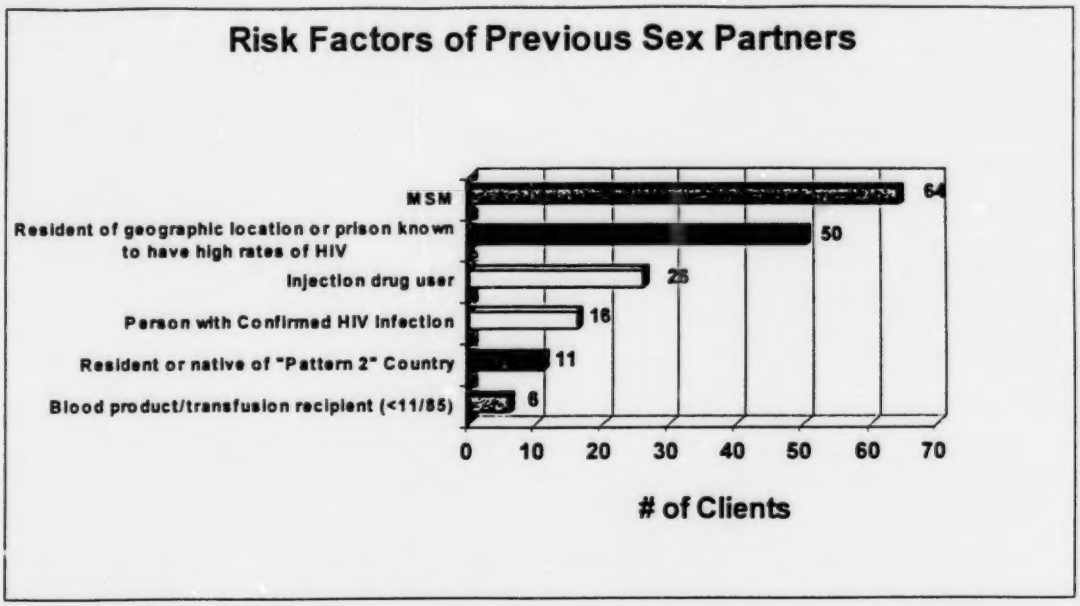


Additional information pertaining to sexual risk behaviours was obtained from the majority of clients. More than one-half of all respondents reported two or more partners in the past year (Range: 0 - 600), and four or more partners in the past 10 years (Range: 1 - 2100). One-quarter of respondents reported more than 10 sexual partners during the past 10 years.

Clients were also asked about the gender of their sexual partners. More than one-third of male respondents (62/185 or 34%) reported sexual experiences with other men, indicating that the project is attracting men who have sex with men. While some men reported sexual activities exclusively with men (22%), others reported having had sexual partners of both genders (12%). Of the female respondents, 94% (168/179) reported sexual activities with men only, 5% reported sexual activities with men and women, and 1% reported only female sexual partners.

Figure 3.3 presents the results of a question asking clients whether they were aware of ever having engaged in unprotected sexual activity with a partner known to have HIV/AIDS or with a variety of risk factors. As shown, a number of clients reported unprotected sexual activities with a partner known to be infected with HIV (16), or at increased potential risk for HIV/AIDS: a man who has sex with men (64), resident of a geographic location or prison known to have high rates of HIV infection (50), injection drug user (26), or a resident or native of a country where heterosexual transmission predominates (e.g., Africa, Caribbean) (11).

Figure 3.3



HIV Testing Behaviours: Past and Present. Responding to questions around HIV-related testing behaviour, 77% of clients indicated they had specifically chosen anonymous HIV testing over nominal or non-nominal approaches. In almost all of these cases (94%), their reasons were related to anonymity concerns. Some clients (41%) indicated they had specifically avoided being tested for HIV before anonymous testing was available. This data corroborates previous research indicating that the absence of anonymous testing may deter some individuals from determining their HIV status. Most clients (69%) reported that they were undergoing their first HIV test. Of the clients who were tested previously (116), the number of earlier HIV tests ranged from one to eight, although the majority reported only having been tested once previously.

Test Results. None of the clients tested positive for HIV. All clients except one tested negative. That client had indeterminate results on two occasions and is most likely HIV-negative. Results are considered "indeterminate" when the confirmatory test fails to establish that the screening test is either positive or negative. These results can usually be clarified over several months. The Canadian Medical Association (1995) recommends that re-testing occur no sooner than 6 weeks following the initial sample and that repeat indeterminate results be considered negative.

3.3.2 Services Provided

Overview. All seven regional Anonymous HIV test sites provided services to clients during the July, 1998 to May, 1999 period. Services included pre- and post-test counselling, including information and referrals to other services if necessary or desired, as well as blood collection. After the startup phase, the number of tests conducted provincially has stabilized at approximately 45 per month (Range: 37-50 between September, 1998 and April, 1999).

The anonymous HIV testing service appears to be geographically accessible to the majority of clients. That is, most clients (86%) reported having travelled an hour or less to access the test site they selected, while 10% travelled more than an hour. Anecdotal reports indicate that some of these individuals had chosen to access a site outside their region to reduce the likelihood of being recognized.

Information is presented in Figure 3.4 on the number of tests by region. More tests were performed in the three larger regions (which have a higher staffing allocation for the pilot) than three of the four smaller regions. As shown, Region 6 had a relatively high volume of tests (third overall) which may have been influenced by historical trends of providing HIV testing in the region. Other factors that can influence regional test volumes include:

- regional population base
- pilot staff allocation
- balance between client testing and outreach
- emphasis on targetting vulnerable populations
- testing by local physicians for HIV, hepatitis and other sexually transmitted infections, and
- other regional or site characteristics.

On the basis of information provided through the AIDS Information Line and pilot sites, some individuals decide they want to be tested for other conditions to which their risk behaviours may have exposed them (Hepatitis B, C or other sexually transmitted diseases), as well as HIV. Since the pilot sites do not provide these other tests in conjunction with anonymous HIV testing, some individuals opt to access their doctors or other Sexual Health Centre services for nominal or non-nominal HIV testing and these other tests. It is more important to them to be tested for all conditions at the same time than to be tested anonymously for HIV. Other individuals access anonymous HIV testing at a pilot site, and follow up elsewhere for the other tests.

Table 3.5 shows the impact of the Anonymous HIV Testing Pilot Project on referrals to the Sexual Health Centres' non-nominal HIV testing service. Only clients who initially accessed Anonymous HIV Testing but were referred for non-nominal HIV testing because of a desire to also be tested for other communicable diseases such as Hepatitis B and C are included. Information relating to Health Regions 6 and 7 is not presented since non-nominal HIV testing is not provided at the respective Sexual Health Centres.

Figure 3.4

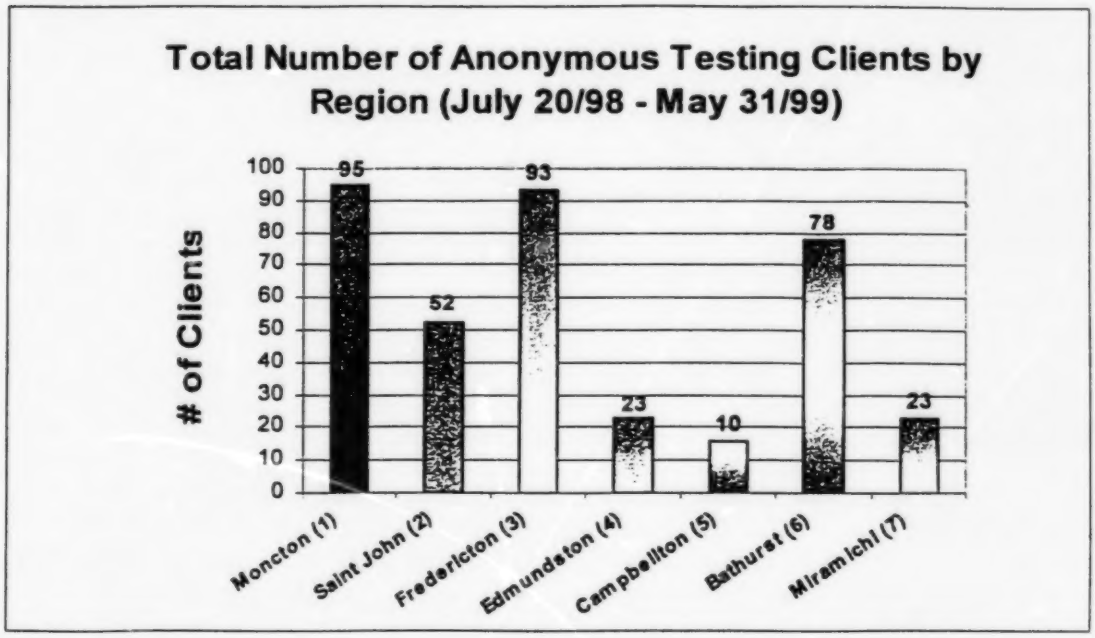


Table 3.5

Approximate Number of Non-Nominal HIV Tests Conducted at the SHC's Following Referrals From the AT Service (July 1998 – May 1999)								
	Health Region							
	1	2	3	4	5	6	7	Total
# of tests	90	84	65	3*	17	N/A	N/A	259

* 3 clients received pre- and post-test counselling at the SHC but were referred to the Hospital for venipuncture (nominal).

Other Quality and Client-Centered Aspects of Service Delivery. Criteria were developed during the design phase for an accessible, client centered/user friendly and quality service. Data presented above have addressed some of these criteria (e.g., geographic accessibility, working in partnership with other agencies that deal with vulnerable populations). Table 3.6 provides additional information on the quality and client-centered features of the AT services. Feedback from clients (Section 3.4) also provides information related to client-centred service criteria (e.g., Clients are comfortable accessing services; testing site and personnel are trusted by target populations).

Table 3.6

Other Quality and Client-Centred Criteria	Data Obtained (July 1998 – May 1999)
Services reflect the principle of informed decision making.	• 100% of clients tested provided informed consent.
Testing site and process is perceived as anonymous by clients.	• 77% of clients had specifically chosen anonymous HIV testing over testing options; 94% of these clients reported that their choice of AT was related to anonymity concerns.
Every effort is made to maximize client return rate.	• 93% of clients returned for their results.
Every effort is made to ensure that clients see the same counsellor for pre- and post-test sessions.	• 91% of clients saw the same counsellor at pre- and post-test.
Sufficient time is provided for pre- and post-test counselling (in accordance with established guidelines).	• Average length of pre- and post-test sessions is consistent with established guidelines, given that no positive results have been obtained. - Pre-test session: Average length=40 minutes (SD=12); Range=15-90 minutes. - Post-test session: Average length=19 minutes (*SD* =9); Range=5-45 minutes.
Every effort is made to ensure that clients receive results in person (acknowledging some exceptional circumstances)	• 99% of all clients received their results in person.
Provincial consistency in the scheduling of post-test sessions (i.e., 3 weeks to allow sufficient time for all regions to receive confirmatory results from Halifax if required).	• Average time between pre- and post-test was 20 days, which conforms with the consensus reached at the provincial training workshop. • However, the interval between pre- and post-test scheduling ranged from 8 to 57, indicating considerable variation and a need to further examine, in conjunction with the regions and laboratories, strategies to minimize the client's wait, while allowing for adequate consistency to reduce unnecessary additional anxiety.
When appropriate, clients are provided with information and referrals regarding other services that could be of benefit and related to determinants of health.	• Information and/or referrals were provided to clients on 536 occasions during pre- and post-test sessions. Information and/or referrals to primary care physicians (e.g., testing for hepatitis and other CD's) were most commonly cited. However, many clients also received information and/or referrals to services such as: professional counselling; AIDS service organizations; self-help/peer support groups; and alcohol/drug treatment.

3.3.3 Impact on HIV-Related Behaviours. Support for the potential risk reduction benefits of HIV testing and counselling can be found in clients' self-reported behaviour and intention data (see Figures 3.5 and 3.6). During the post-test counselling session, clients were asked whether they: (1) Had changed their HIV-related risk behaviours since the pre-test session; (2) Intended to change their future HIV-risk behaviours; and (3) Intended to suggest HIV testing to their sexual or injection equipment sharing partners.

(1) In total, more than one half of respondents (52%) reported a decrease in risk behaviours in the interval between pre- and post-test, and 20% reported no change (see Figure 3.5). Only two clients reported an increase in risk behaviours (1) or that they did not know (1). The question was deemed non-applicable for 28% of clients (i.e., clients who had either never engaged in risk behaviours or who had already made the necessary risk reduction changes before the pre-test session).

The reported behavioural benefits of pre-test counselling are particularly evident when excluding the subset of clients for whom the question was non-applicable. That is, 71% of all clients for whom the question was applicable reported decreases in HIV-related risk behaviours in the pre- to post-test interim.

(2) As shown in Figure 3.6, close to two-thirds of all clients at post-test reported intentions to reduce their future HIV-related risk behaviours. Nine percent of respondents did not intend to change their behaviours, and approximately 30% of all clients reported that the question was non-applicable since they had no need to change their behaviours. Only three respondents cited either not knowing what their risk reduction intentions were or intentions to increase their risks. A total of 82% of the subset of clients who found the question applicable and for whom data was provided reported intentions to reduce HIV-related behaviours.

(3) A significant proportion of respondents (64%) also reported intentions to suggest HIV testing to sexual/injection equipment sharing partners. In total, 31% of respondents said that they would suggest HIV testing to all of their partners, and another 33% said they would suggest testing to some of them.

Supporting data on the beneficial behavioural impact of New Brunswick's anonymous HIV testing service can also be found in clients' responses to the feedback form (see Section 3.4).

Figure 3.5

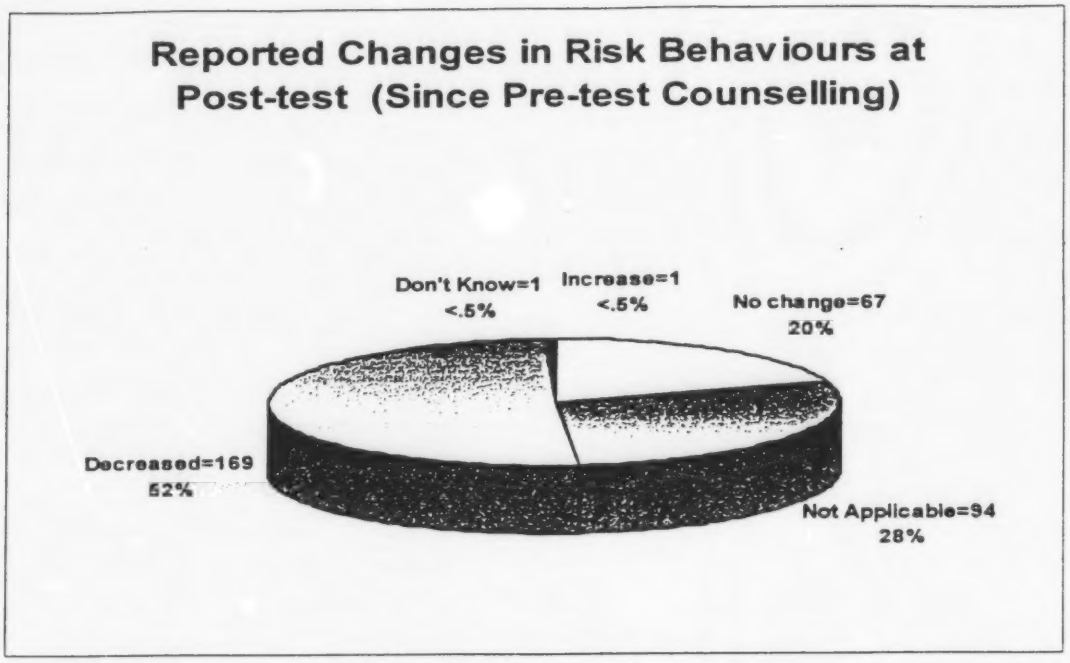
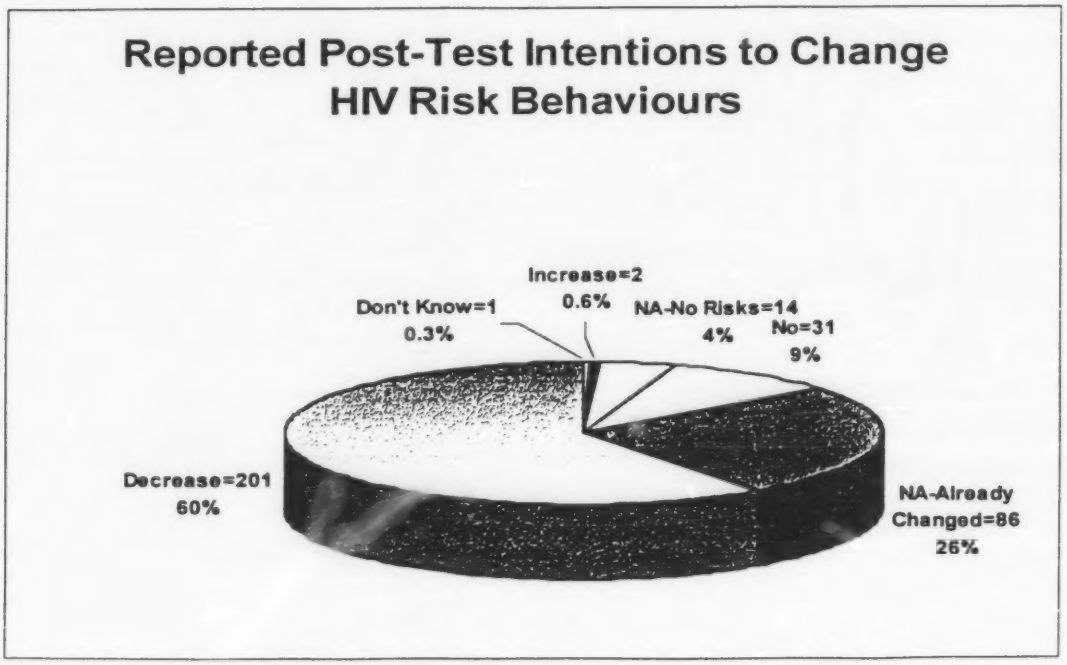


Figure 3.6



3.4 Client Feedback

A total of 310 feedback forms were completed by clients, and provide much corroborative evidence regarding the usefulness and benefits of the Anonymous HIV Testing service. Designed to gather information on client perceptions of the service, the client feedback form is optional and is completed anonymously immediately following pre- and/or post-test sessions. Forty three percent of the forms returned to the end of May 1999 had been completed at pre-test and 55% at post-test (2% of clients reported another reason for their visit or did not answer the corresponding question). Data is presented below on client perceptions of the service's helpfulness, whether they would have been tested in the absence of certain anonymity conditions, and of the service's impact on their future HIV-related behaviours.

Responses to the question "Were the services at this clinic helpful to you?" were positive from virtually all clients. While five clients did not answer the question, and one client said "sort of", all others (303, 97%) replied "yes". An open-ended question, asking clients to explain why the services were or were not helpful, was completed by approximately one-half (149) of the respondents. As shown in the Appendix, comments were positive in almost all cases, and can be summarized in relation to the following themes:

- **Clarity and Relevance of Information Provided (42).**

  e.g., *"Everything was very informative; answered a lot of questions I was requiring."*
  "Material related to the test and related matters were thoroughly covered by the counsellor. The nurse was very friendly and helpful in giving me information and answering my questions."

- **Client Centered/User-friendly aspects (39)**

  e.g., *"They offered information, were gentle and kind. Made you feel very comfortable."*
  "Extremely. I got in for testing the day of my call. I was able to receive my results earlier than anticipated. This alleviates a lot of stress."

- **Importance Value of Service/Anonymity (26)**

  e.g., *"I always wanted to know if I was in contact with HIV, but was afraid to ask and wanted it to be anonymous."*
  "I would never have tested if I had to give my name."
  "I just couldn't go to my doctor for this.""

- **Importance of Knowing One's Status (16)**

  e.g., *"I got to know whether I was negative or positive which is more safe for me and my partners."*
  "Gave me peace of mind."

- **Miscellaneous (26)**

  e.g., *"It is very local to people who need it."*
  "Les intérvenantes ont une bonne formation et font bien leur travail"/The staff have good training and do their work well."

The Client Feedback data also support previous conclusions that the absence of anonymity prevents some individuals from seeking HIV testing. Close to one-half reported that they would not have been tested if the test and test result was not anonymous (43%) and one-third said they would not have sought testing if they had to give their names (33%). A substantial proportion did not know whether they would have been tested under these conditions (19% if the test/test result was not anonymous; 22% if their names were provided). These findings suggest that the service is meeting the expressed needs of some clients for an anonymous service, as well as being a point of access to HIV testing and counselling for other clients who are not necessarily concerned with anonymity or opposed to giving their name.

Feedback received from clients also highlights the benefits of HIV-related testing and counselling on future HIV-related risk behaviours. That is, more than three-quarters of all respondents (79%) reported that they would "take fewer risks" when asked, "In what way, if any, do you think talking to a counsellor and being tested for HIV/AIDS will affect your future HIV/AIDS risk behaviour?"

A total of 42% of clients took the opportunity to provide additional comments (i.e., "Is there anything else you would like to tell us?"). As shown in the Appendix, a number of the comments (44/147) overlapped with the themes discussed earlier (i.e., Client-centered/user friendly aspects; importance and value of service/anonymity). However, other themes identified through the additional comments reflected: general satisfaction and gratitude (28); specific suggestions (27); and impact on knowledge and behaviours (10). The majority of specific suggestions pointed to a desire for simultaneous screening for hepatitis and other STI's. The remainder of the comments could not be classified under a particular theme (see Appendix)

4.0 Status Assessment and Recommendations

4.1 Summary of Successes

The data gathered from various sources since the launching of the Anonymous HIV Testing Pilot Project indicate many successes in relation to the provision of an accessible and quality service to New Brunswick's population. The results gathered over the first 10 months provide corroborative support to previous research indicating that anonymous HIV testing is advantageous in attracting individuals who have concerns about the confidentiality of test results, and in relation to encouraging testing among individuals whose behaviours place them at high risk for HIV.

Regional staff provided education and counselling related to the reduction of risk behaviours that transmit HIV and other communicable diseases to the 380 clients who accessed the testing service. Almost all clients who were willing to discuss personal risk exposures reported one or more risk factors for HIV. Many had previously avoided HIV testing, and would not have been tested in the absence of the anonymous option. More importantly, the majority of clients reported a reduction in HIV-related risk behaviours in the interval between pre- and post-test and intentions to take steps to reduce their risks in the future. In addition, the majority of clients received information and/or referrals regarding other potentially beneficial services related to various determinants of health (e.g., primary care physicians, addiction treatment centres, self-help/peer support, AIDS Service organizations).

The number of individuals tested anonymously for HIV in New Brunswick is a small proportion of all individuals having HIV tests, as is the case in most other jurisdictions offering anonymous HIV testing. Comparative data on risk factors for all of those having nominal or non-nominal HIV tests is not available. Hence, it is not feasible in New Brunswick at this time to compare levels of risk among clients accessing the different types of tests, or the impact of testing and counselling among the different groups.

No HIV positive results were reported from the pilot between July 1998 - May 1999, so early detection has not yet been demonstrated. However, evidence from other jurisdictions, as summarized in Section 1.2.1, indicates that anonymous HIV testing is an important option for some persons at risk, and significant in helping them reduce risks. Data from this New Brunswick pilot is consistent with these findings.

Current epidemiological evidence highlights the significance of social and economic marginalization to the increasing incidence of HIV among vulnerable populations. Addictions, sexual abuse, homelessness, and poverty are some of the factors that render individuals particularly vulnerable to HIV-infection. New Brunswick is not immune to these elements and provincial data underscore the increasing prevalence of risk behaviours (e.g., crack-cocaine) which have been associated with rapid increases in HIV and hepatitis infection rates elsewhere.

Taking appropriate and proactive measures at this time (i.e., when New Brunswick's rates of known cases are relatively low in comparison to other areas in the country), can maximize this province's ability to prevent future infections.

The provision of anonymous HIV testing is only one element in preventing HIV/AIDS. However, great strides have been made provincially and regionally in strengthening the lines of communication between Public Health and key partners. Intersectoral partners include AIDS organizations, gay/lesbian/bisexual organizations, Department of Education and educational facilities, First Nations communities, Department of the Solicitor General and the Correctional Service of Canada, correctional facilities, etc. Health and social service partners include physicians and nurses, including those providing services to individuals with HIV/AIDS infection, addiction services, various social services and agencies they work with, and mental health. The initiation and strengthening of such partnerships has not only been instrumental in the project's ability to reach some of New Brunswick's vulnerable populations, but also provides necessary groundwork for future initiatives involving the complex factors rendering individuals at risk for HIV.

4.2 Issues and Recommendations

The evaluation data gathered to date support the rationale and viability of the project's basic design and of providing anonymous HIV testing through the Sexual Health Centres across New Brunswick's seven Health Regions.

Despite the accomplishments, it is clear that much work remains in reducing the spread of HIV and other communicable diseases. Over the course of the current evaluation period, a number of issues have come to the forefront. Some of these issues, options for consideration, and recommendations are presented below. While some can be dealt with regionally, others will require policy consideration at the provincial level.

1. **Meeting of Anonymous HIV Testing Team Members and Provincial Stakeholders**

   A provincial meeting of Regional Anonymous HIV Testing team members and provincial stakeholders to discuss issues related to the ongoing implementation and evaluation of anonymous HIV testing has been recommended by team members in all regions. Regional teams now have close to one year of anonymous HIV testing experience, and have expressed a need to meet in order to share successes and difficulties, brainstorm challenges, as well as to discuss implementation plans and strategies. The input and feedback from stakeholder groups and vulnerable populations (e.g., Aboriginal, Corrections, injection drug users, homeless, gay/bisexual men, youth) is also deemed necessary toward ensuring that New Brunswickers at greatest risk for HIV and other infections are successfully reached through the program.

Recommendation:

As requested by the regions, a provincial meeting of Regional Anonymous HIV Testing Team members (e.g., RTM's, PHN's, Administrative Support Staff) and key stakeholders is recommended as an important step in the transition from pilot project to regular Public Health program. The content and process of this meeting would be most effective if based on information gathered from a brief needs assessment of Regional HIV Testing Team members and provincial stakeholders. To ensure an effective and efficient transition from pilot project to regular program, it is suggested that the planning required for this meeting be launched promptly following a decision regarding program continuity.

2. Continued Regional Partnership Development

The partnership-building and outreach initiatives are developmental in nature and must continue to evolve to reach New Brunswick's vulnerable populations. While work has been initiated in all regions in relation to building partnerships with key stakeholders who can assist in reaching individuals particularly susceptible to HIV, the level and time dedicated regionally to communication and outreach has varied substantially. For instance, while all regions have targetted New Brunswick's youth, not all have explored the possibilities with other populations (e.g., addictions, Aboriginal, prison).

Recommendation: It is neither realistic nor desirable to expect regional uniformity in the approach and time taken for such activities. The anonymous HIV testing sites must deal with differing regional population bases, different pilot staff allocation (0.5 FTE PHN in Regions 1-3 versus 0.2 in Regions 4-7), and varying demands for anonymous HIV testing. However, it is recommended that closer attention be paid by all test sites to assessing regional needs and achieving a greater balance between the time actually spent on the provision of direct services (counselling and testing) and partnership-building/outreach efforts.

3. Concurrent Testing

Some clients, testing sites, and other stakeholders (e.g., AIDS Service Organizations) have recommended that testing for other infections associated with similar risk factors as HIV (sexually transmitted or blood-borne, e.g. through intravenous drug use) be available on a non-anonymous basis through the anonymous HIV test service. This may include blood tests for Hepatitis B, C, or syphilis, or other tests for chlamydia or other sexually transmitted infections. This practice occurs in most other jurisdictions that provide anonymous HIV testing, and can be supported in the data linking various STI's to an increased susceptibility to HIV infection.

The data collected thus far has indicated that a number of clients who access anonymous HIV testing also want to be screened for other related diseases (e.g., hepatitis). Since this is not part of the anonymous HIV testing pilot, these clients decide to undergo anonymous HIV testing and to be referred elsewhere for other tests or opt for non-nominal HIV and other testing simultaneously.

Referring clients elsewhere for STI screening can be potentially problematic in several respects. For instance, clients referred elsewhere may not follow through with testing. Added costs to the health care system could also occur in terms of additional cases of transmission or by virtue of the time/expense in consulting with different service providers.

Recommendation: A number of policy and procedural issues would need to be addressed before moving forward with other testing. It is suggested that the Public Health Management Service and Regional Team members collaboratively explore the feasibility, requirements, benefits and constraints of providing simultaneous testing for other infections associated with similar risk factors as HIV on a non-anonymous basis through the anonymous HIV test service.

4. **Increased Collaboration with First Nation Communities**

A number of communication, partnership-building, and outreach initiatives with First Nation Communities have been launched both provincially and regionally in relation to the anonymous HIV testing project. Given the steadily increasing incidence of HIV infection among Canada's Aboriginal peoples, ongoing efforts are needed to ensure that anonymous HIV testing is culturally relevant and accessible to New Brunswick's First Nation communities. The Atlantic First Nations AIDS Task Force (AFNATF) has also strongly urged that information pertaining to ethnicity be collected as part of the Anonymous HIV Testing evaluation strategy:

"As we have discussed, the need for population demographics and something that identifies First Nation participation in the program is very important for the work that our office is engaged in. Our leadership and communities need to be aware of the issues that we are facing; the statistics for the province are not sufficient to create the picture of HIV in NB First Nation communities."

Recommendation: It is recommended that PHMC further explore and consider AFNATF's ethnicity-related recommendation. As well, it is suggested that the need and feasibility of providing anonymous HIV outreach testing within New Brunswick's First Nation Communities be collaboratively discussed with key players. This could involve building on the networking and partnerships established thus far (e.g., with Atlantic First Nations AIDS Task Force; Union of New Brunswick Indians; certain communities/reserves) and exploring issues related to Federal/Provincial jurisdiction, funding arrangements, logistical considerations, etc.

5. **Exploring Possibilities within Correctional Facilities**

National data indicate that rates of infection among prison populations are at least ten times higher than in the general population, and are continuing to increase in both federal and provincial prisons. There were reports of 9 HIV positive inmates and one living with AIDS in federal correctional facilities in New Brunswick in January 1999 (i.e. prevalence, not new cases). Comparable data for provincial facilities is not available.

The provision of anonymous HIV testing by agencies independent of the correctional system has been recommended as a way of increasing the incidence of HIV testing - and thereby facilitating early detection and further prevention - among inmates who avoid testing out of fear that their test results will not remain confidential and that they will be stigmatized by staff and other inmates.

Representatives of both the provincial and federal correctional systems in New Brunswick have expressed interest in Public Health's involvement in the provision of anonymous HIV testing. More specifically, the Department of the Solicitor General is receptive to the idea of piloting anonymous HIV testing within one provincial facility. Federally, CSC National Headquarters has expressed interest in an anonymous HIV testing pilot project in one of New Brunswick's federal prisons. Discussions with these stakeholders, as well as Public Health representatives from Saskatchewan, who have years of experience providing anonymous testing within the correctional system, have pointed to some possibilities around anonymous HIV testing in New Brunswick's correctional facilities.

Recommendation: A number of steps must be taken and various key issues addressed prior to moving forward. Among the issues to be considered are: What services would be provided and by whom? What type of funding/contractual arrangements would be made? What are the legal/liability issues? Which correctional sites would be most suitable? What role would correctional staff play? How would anonymity be ensured within the prison environment?

While these issues are being addressed, time could effectively be used by Public Health staff in gaining credibility within and familiarity with the correctional environment (i.e., building a solid foundation for future prevention efforts through additional outreach and partnerships). This could involve initiatives such as: Providing HIV-related information and educational sessions to correctional staff; consulting with prison administration, unions, personnel and inmates around the feasibility and logistics of anonymous HIV testing; and preparing and distributing information on anonymous HIV testing services for inmates preparing to be released.

6. Prenatal HIV testing

Seroprevalence research of pregnant women in New Brunswick (Getty et al., 1997) indicated 4 cases of infection in a year of testing. Since maternal-infant HIV transmission can be significantly reduced by appropriate measures (e.g. treatment or caesarean section), it is important that women who are HIV positive are aware of their infection early in pregnancy. Infection rates in infants can be reduced by approximately two-thirds if drug treatment is started early in the course of pregnancy. This highlights the importance of HIV testing (with informed consent and counselling), being offered and done consistently among prenatal women, a policy being implemented in provinces and territories across the country.

Recommendation: Ongoing communication and partnership-building with the New Brunswick Medical Society is suggested. This could facilitate the sharing of information with New Brunswick physicians and pregnant women about the benefits of HIV testing (with informed consent and

appropriate pre- and post-test counselling) for all pregnant women as well as reinforcing the various testing options available (i.e., nominal, non-nominal and anonymous). It could also lead to the development of a policy in this regard through an appropriate mechanism.

7. Proceeding with the Evaluation Strategy

A variety of quantitative and qualitative data sources and evaluation methodologies have been used in the evaluation of the Anonymous HIV Testing Pilot Project. An ongoing monitoring and evaluation strategy will be required should anonymous HIV testing become an ongoing program of the Department of Health and Community Services. This would facilitate strategic planning, provincial and regional accountability, as well as an assessment of the program in relation to meeting the needs of New Brunswick's vulnerable populations.

Recommendation: In consultation with the Anonymous HIV Testing Regional Team members, Program Analysis and Evaluation, the Provincial Epidemiology Service, and other stakeholders (e.g., AIDS Service Organizations), identify the essential elements and data sources to be gathered within the context of an ongoing (versus pilot) program. The process for data collection and reporting should also be outlined.

Preventing HIV transmission among youth, vulnerable populations, and other individuals with risk factors is one of the public health challenges facing New Brunswick, and other Canadian jurisdictions in coming years. It is most effective and efficient to proactively address this issue before epidemic conditions for transmission are reached.

The work of the anonymous HIV testing teams in all health regions, in conjunction with other stakeholders, appears to be making a significant contribution in addressing this issue in a constructive and intersectoral way in this province. As noted above, several issues have arisen in the course of this work which warrant attention. Some can be effectively dealt with at the regional level. Others require further policy consideration at the provincial level. Their resolution and further progress will be facilitated if there is an understanding that an anonymous HIV testing service, provided in conjunction with outreach and partnership development, will become an ongoing part of the service continuum in New Brunswick as it is in almost all other Canadian jurisdictions.

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APPENDIX

Anonymous HIV Testing Pilot Project

July 1998 - May 1999

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I. Counsellor Checklist (N = 380)

1.0 Client Characteristics

1.1 Demographic Information

Figure 1

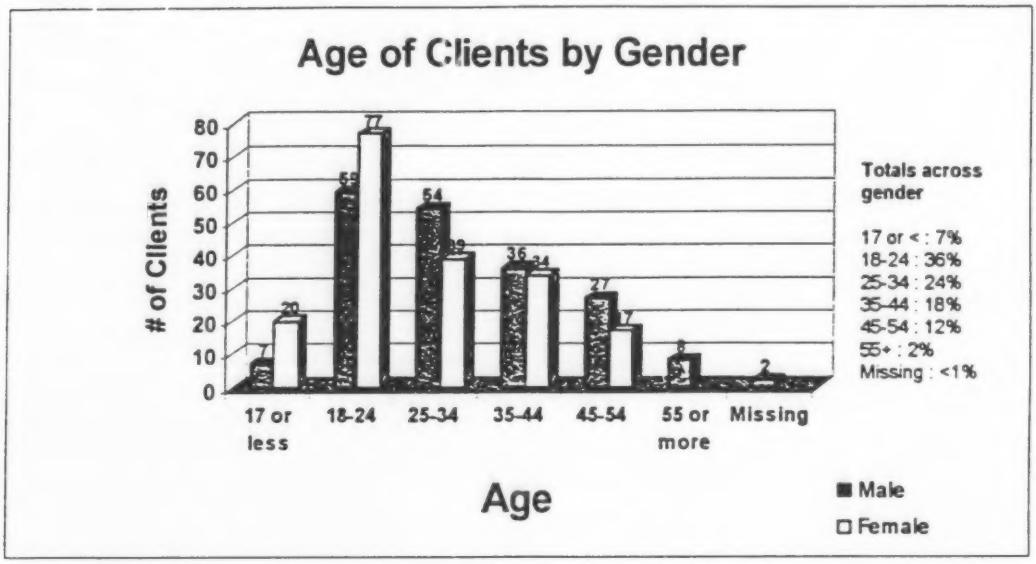
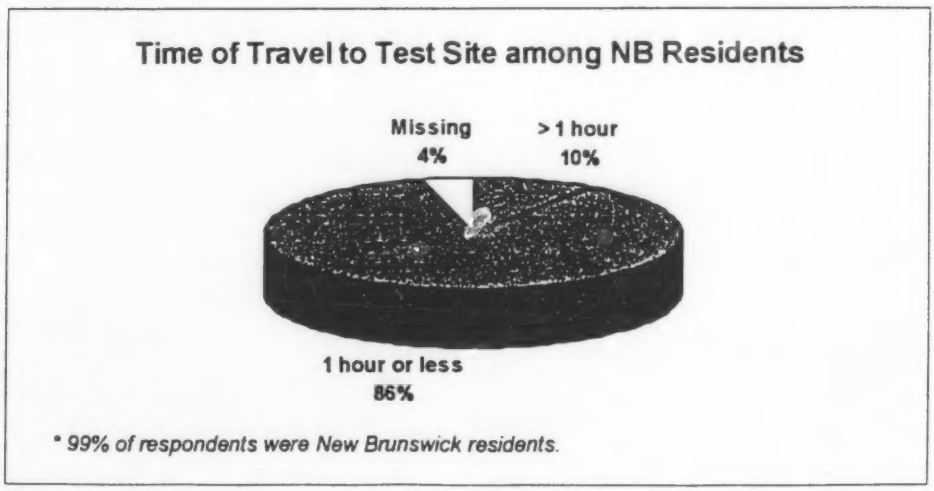


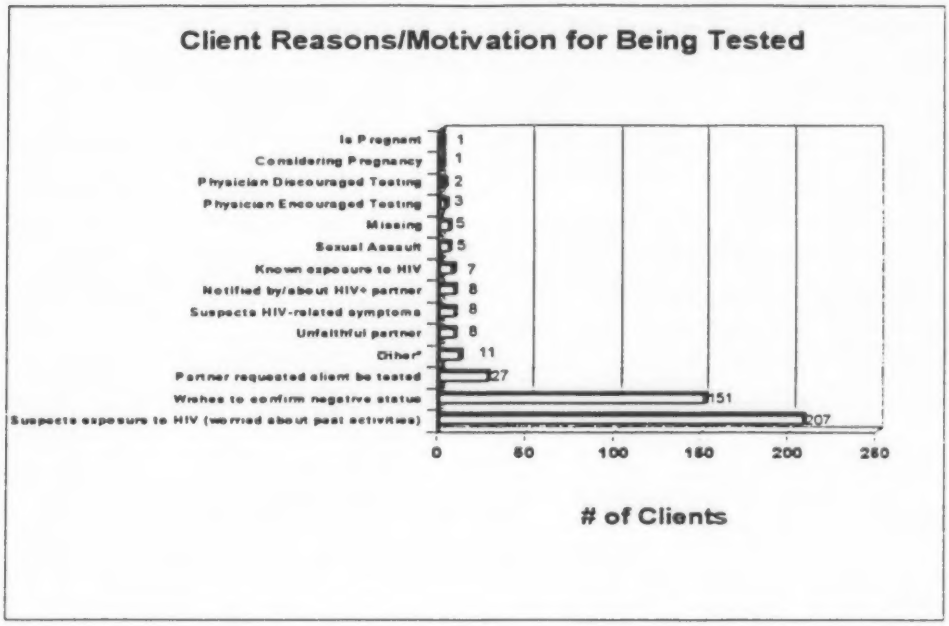
Figure 2



* *99% of respondents were New Brunswick residents.*

1.2 Reasons for Requesting HIV Testing

Figure 3



1.3 HIV-Related Risk Behaviours

Figure 4

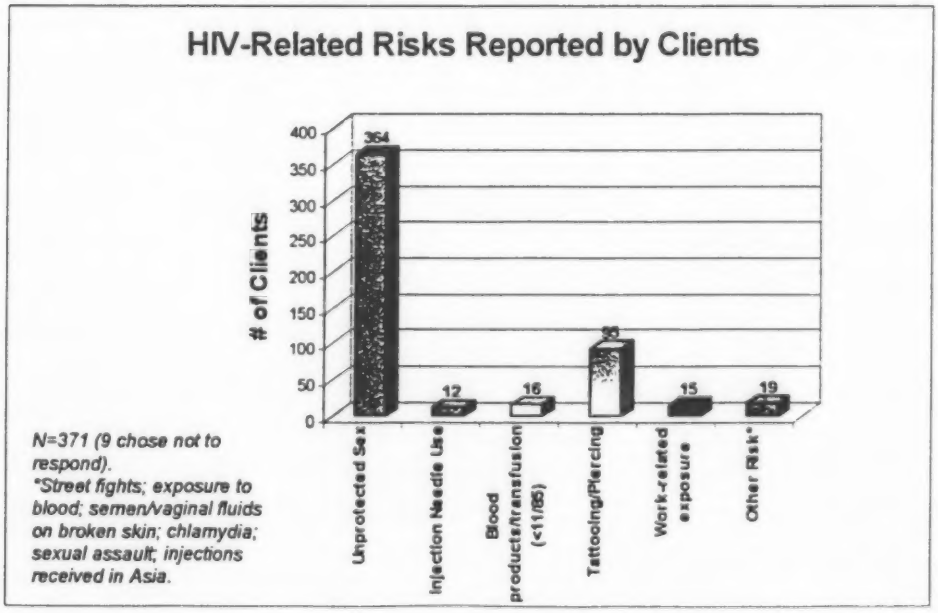
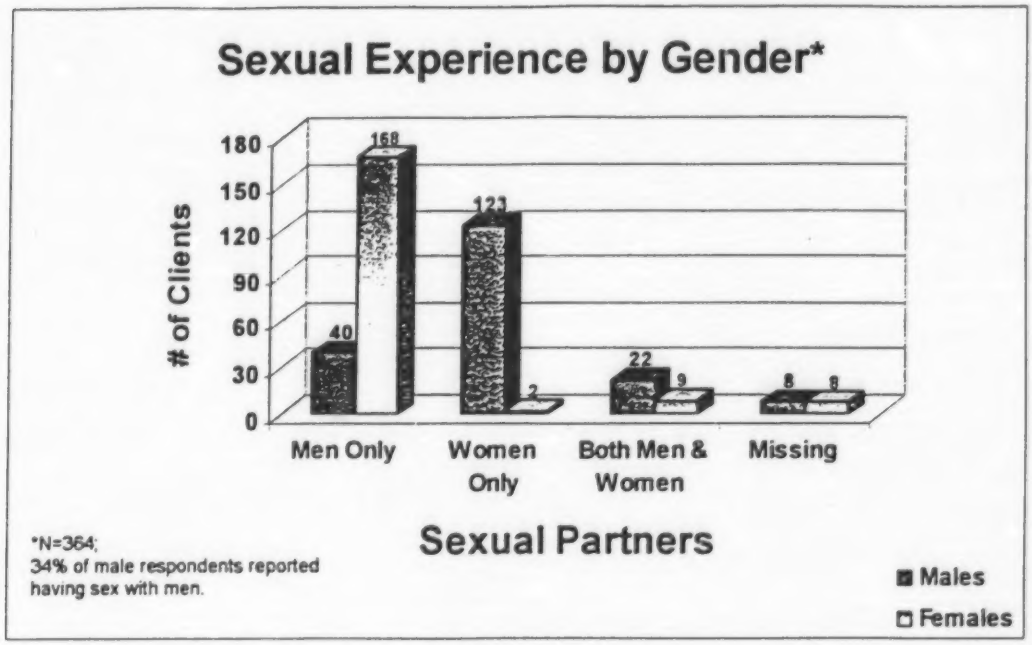


Figure 5



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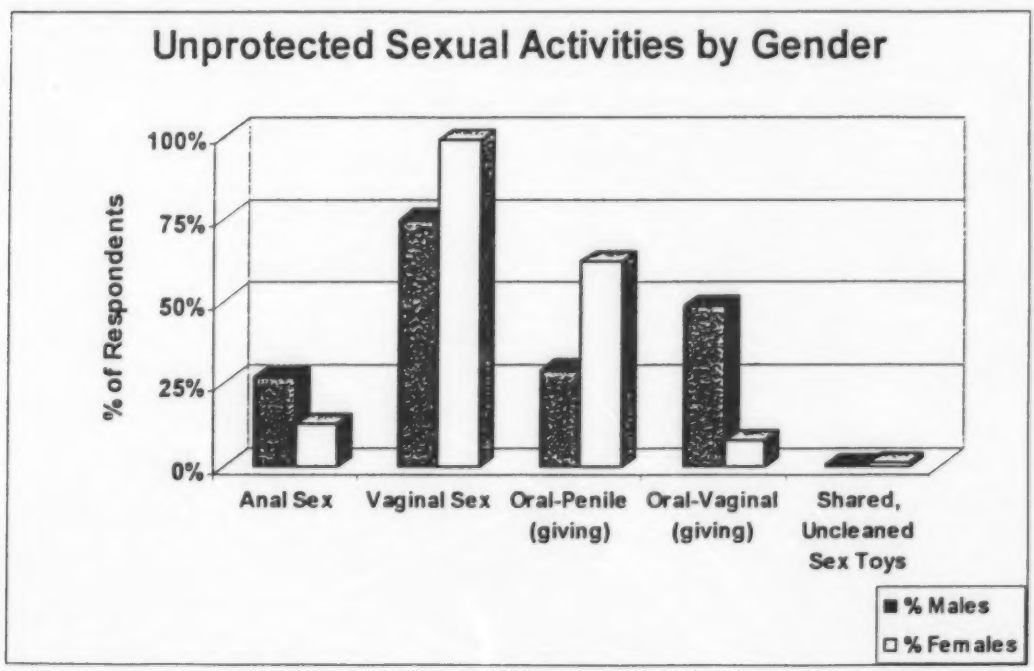


Table 1: Number of Sexual Partners

Statistic	# of Sexual Partners	
	Last Year	Last 10 Years
Minimum	0	0
Maximum	600	2100
Median	2	4
100 or more	3	10

Figure 7

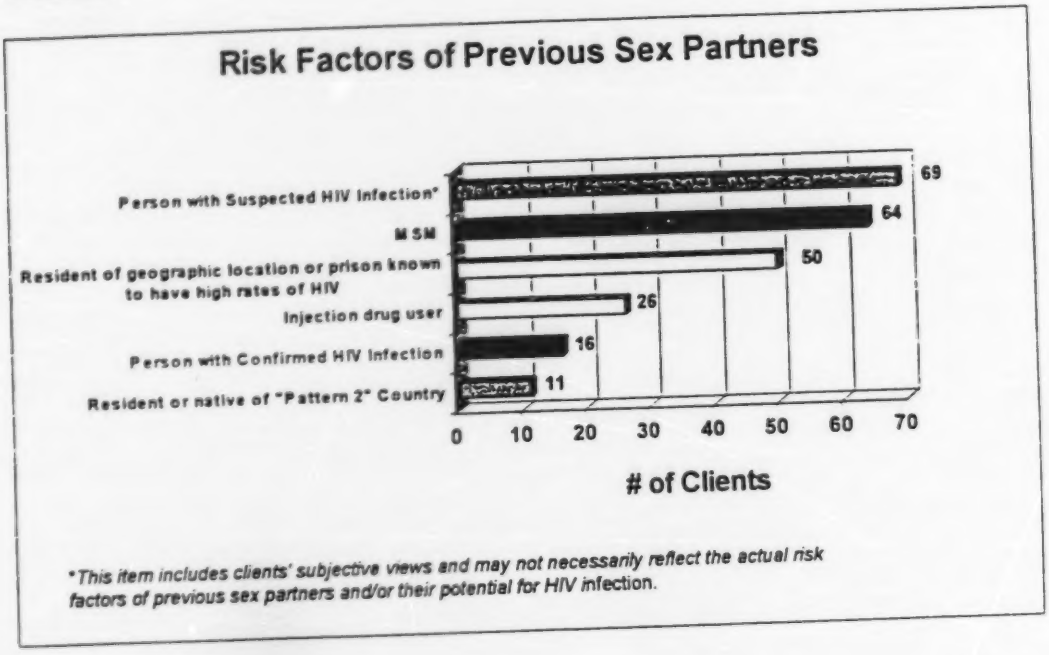
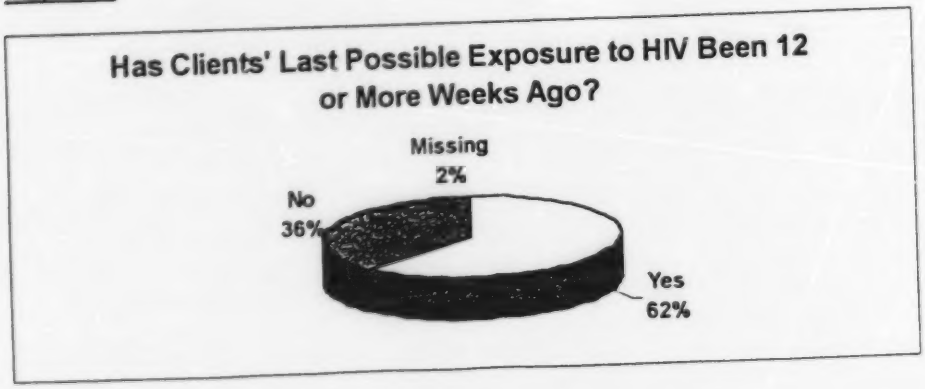


Figure 8



1.3 HIV Testing Behaviours: Past and Present

Figure 9

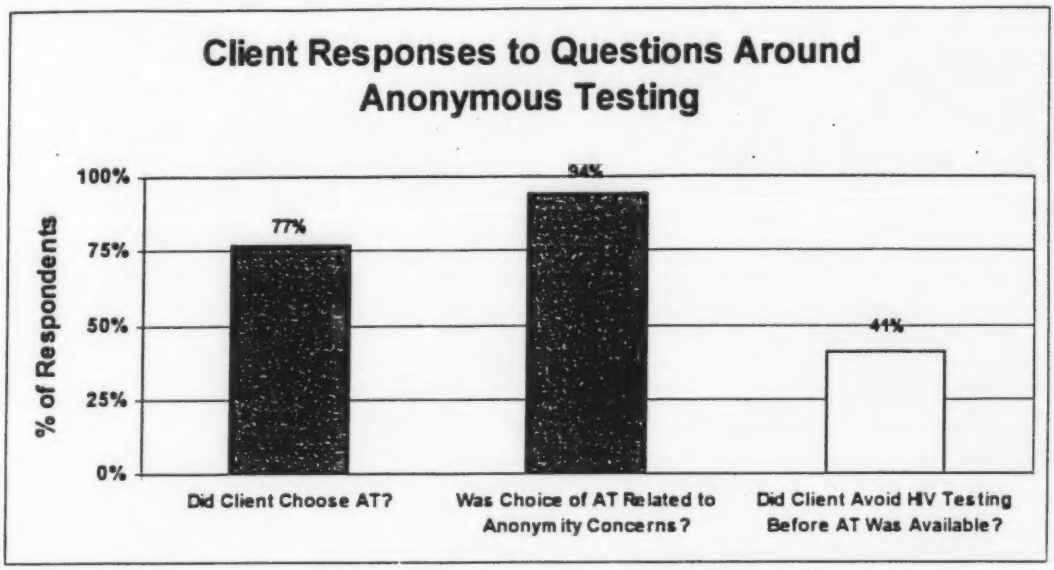


Figure 10

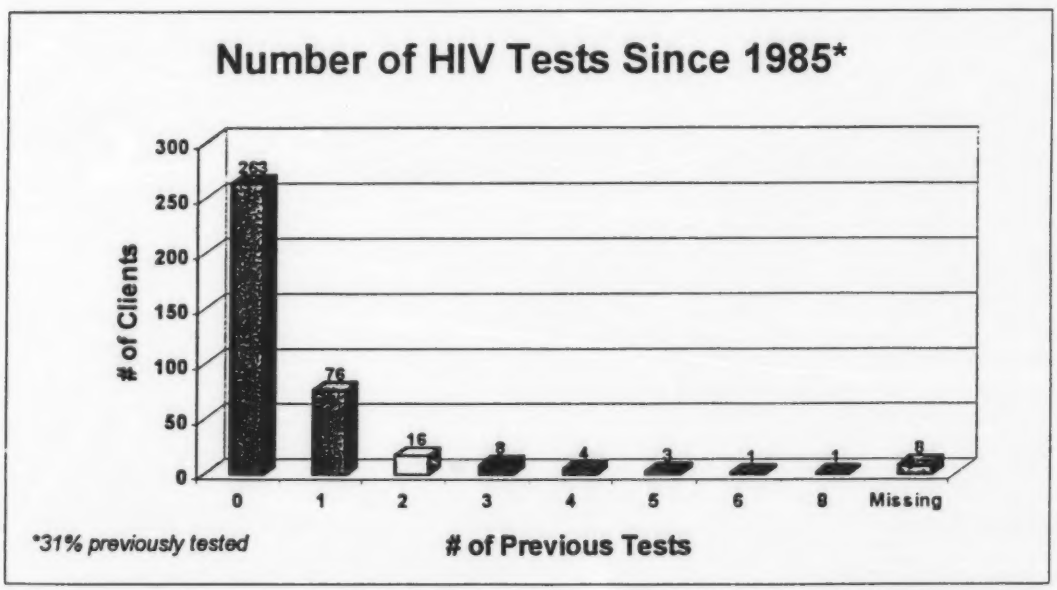


Figure 11

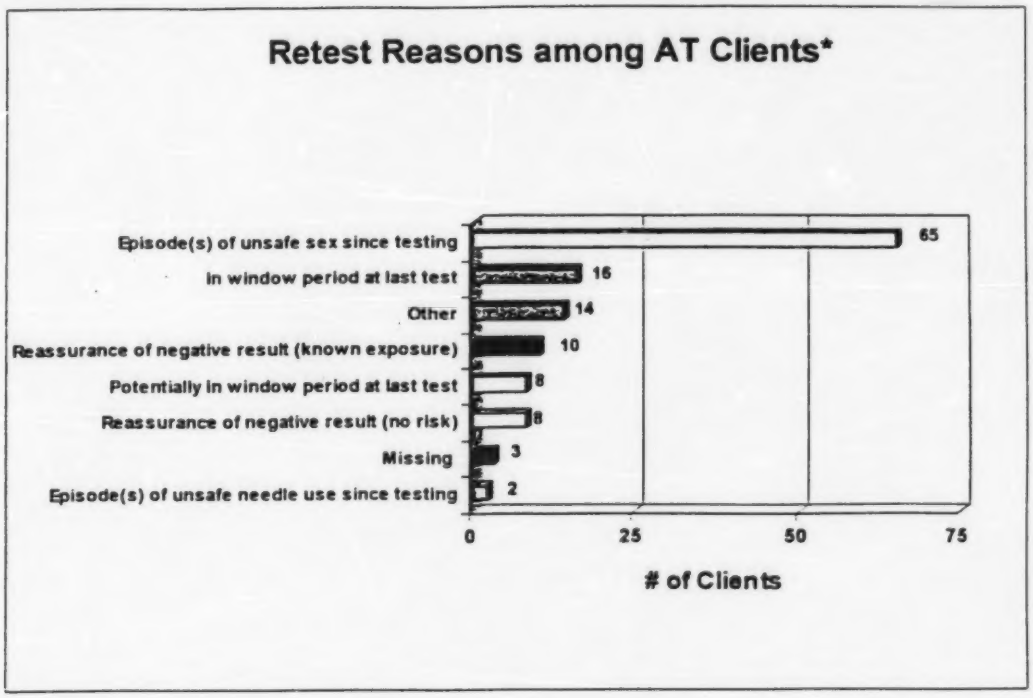


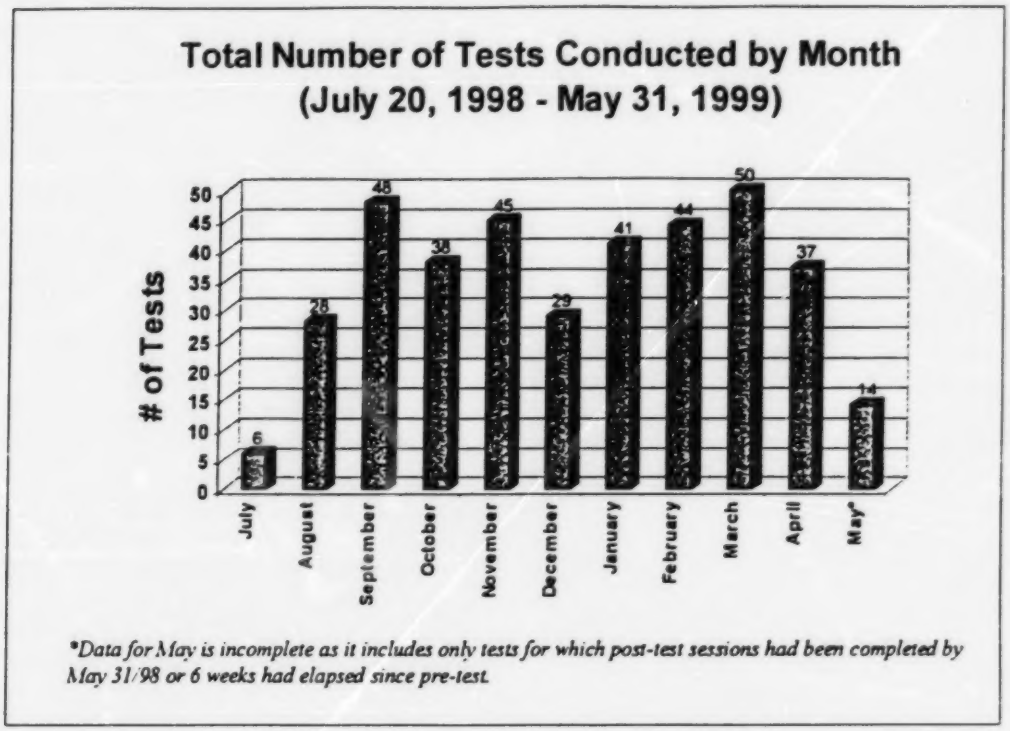
Table 2: How did Client Find Out About Anonymous Testing?

Compilation of How Clients Found out About the AT Service		
	Total	**% of Total**
AIDS NB Toll-Free Information Line	25	6.6%
AIDS Service Organization (excluding toll-free line)	26	6.7%
Has been to this clinic before	18	4.8%
Media	22	5.8%
Missing	3	0.8%
Other	24	6.4%
Other professional, agency, or site	39	10.3%
Other Word of Mouth	63	16.7%
Outreach by testing site staff	13	3.4%
Partner (sexual and/or needle sharing)	23	6.1%
Physician	24	6.4%
Posters, Brochures, Wallet Cards	88	23.3%
Public Health (non SHC)	7	1.9%
SHC	71	18.8%
Website/links	2	5.3%
Total sample	380	

2.0 Services Provided

2.1 Overview

Figure 12



**Data for May is incomplete as it includes only tests for which post-test sessions had been completed by May 31/98 or 6 weeks had elapsed since pre-test.*

Figure 13

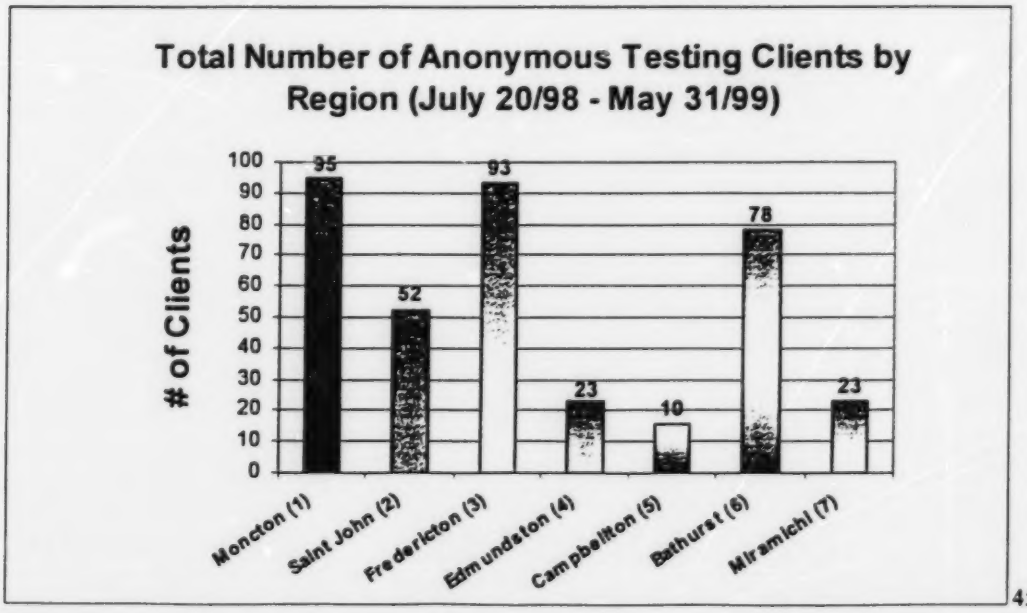


Table 3: Pre- and Post-Test Information Given about Additional Services

Additional Service	At Pre-test		At Post-Test	
	Total	% of Total	Total	% of Total
Primary Care Physician	154	40.5%	14	4.0%
Community-based AIDS Organization	44	11.6%	4	1.1%
Alcohol/drug treatment	11	2.9%	1	0.3%
Self-help/peer support group	27	7.1%	1	0.3%
Professional Counselling	81	21.3%	4	1.1%
Re-test			54	15.3%
HIV/AIDS Clinic	63	16.6%	1	0.3%
Other**	52	13.7%	25	7.1%

** *"Other": Testing for Hepatitis B, C, other STD's (58); Safer sex (8); Hepatitis B vaccine (6); and Miscellaneous (5).*

2.2 Quality and Client-Centered Aspects of Service Delivery

Table 4: Summary of Various Quality and Client-Centered Criteria

Other Quality and Client-Centred Criteria	Data Obtained (July 1998 – May 1999)
Services reflect the principle of informed decision making	100% of clients tested provided informed consent.
Testing site and process is perceived as anonymous by clients	77% of clients had specifically chosen anonymous HIV testing over testing options; 94% of these clients reported that their choice of AT was related to anonymity concerns.
Every effort is made to maximize client return rate	93% of clients returned for their results.
Every effort is made to ensure that clients see the same counsellor for pre- and post-test sessions	91% of clients saw the same counsellor at pre- and post-test.
Sufficient time is provided for pre- and post-test counselling (in accordance with established guidelines)	Average length of pre- and post-test sessions is consistent with established guidelines, given that no positive results have been obtained. - Pre-test session: Average length=40 minutes (SD=12); Range=15-90 minutes. - Post-test session: Average length=19 minutes (*SD* =9); Range=5-45 minutes.
Every effort is made to ensure that clients receive results in person (acknowledging some exceptional circumstances)	99% of all clients received their results in person.

Provincial consistency in the scheduling of post-test sessions (i.e., 3 weeks to allow sufficient time for all regions to receive confirmatory results from Halifax if required).	Average time between pre- and post-test was 20 days, which conforms with the consensus reached at the provincial training workshop. However, the interval between pre- and post-test scheduling ranged from 8 to 57, indicating considerable variation and a need to further examine, in conjunction with the regions and laboratories, strategies to minimize the client's wait, while allowing for adequate consistency to reduce unnecessary additional anxiety.
When appropriate, clients are provided with information and referrals regarding other services that could be of benefit and related to determinants of health.	Information and/or referrals were provided to clients on 536 occasions during pre- and post-test sessions. Information and/or referrals to primary care physicians (e.g., testing for hepatitis and other CD's) were most commonly cited . However, many clients also received information and/or referrals to services such as: professional counselling; AIDS service organizations; self-help/peer support groups; and alcohol/drug treatment.

Table 5: Length of Pre- and Post-test Counselling Sessions

	Length of Session (minutes)	
Statistic	**Pre-test**	**Post-test**
Mean	40	19
Standard Deviation	12	9
Median	40	15
Minimum	15	5
Maximum	90	45

Figure 14

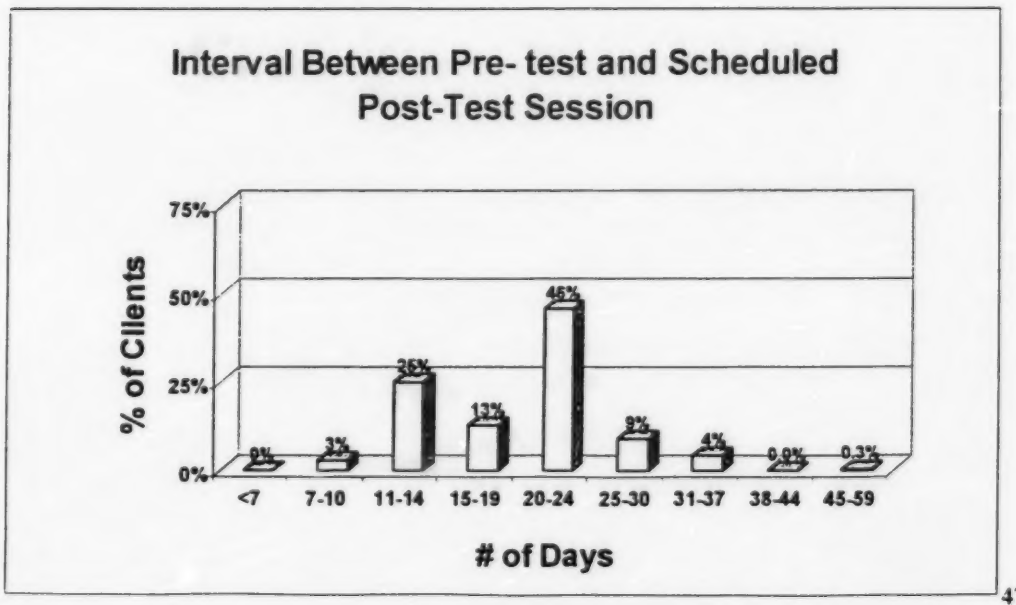
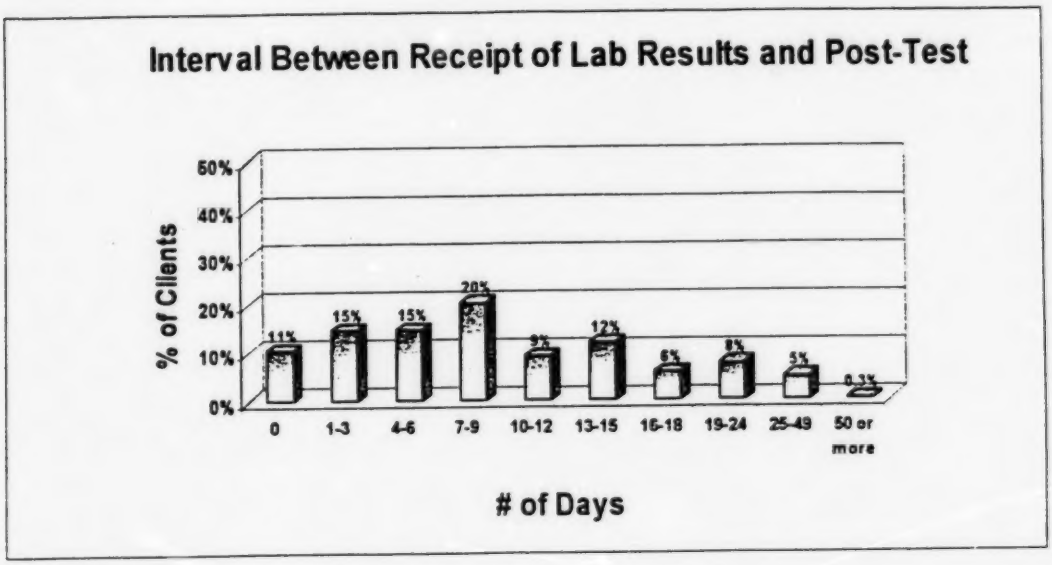


Figure 15



3.0 Impact on HIV-Related Behaviours

Figure 16

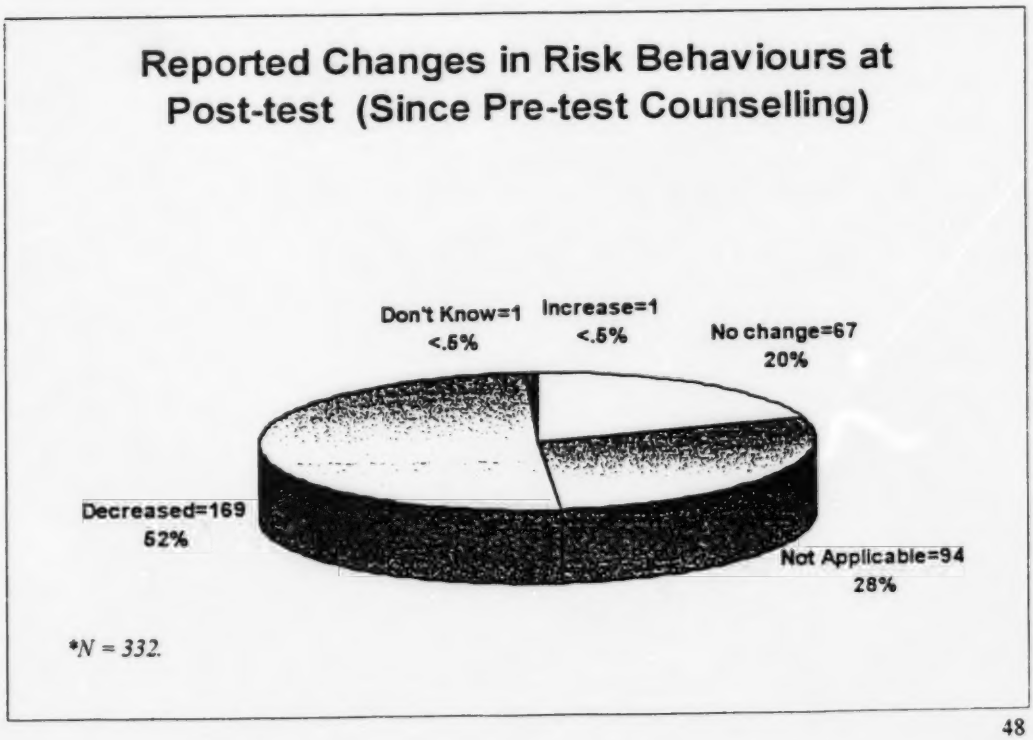


Figure 17

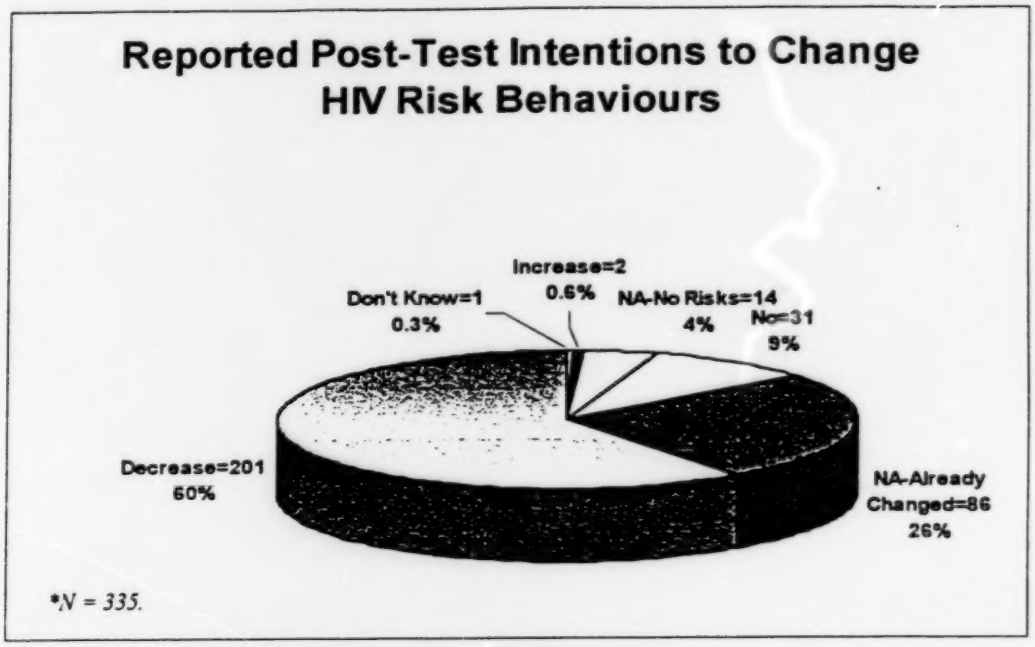
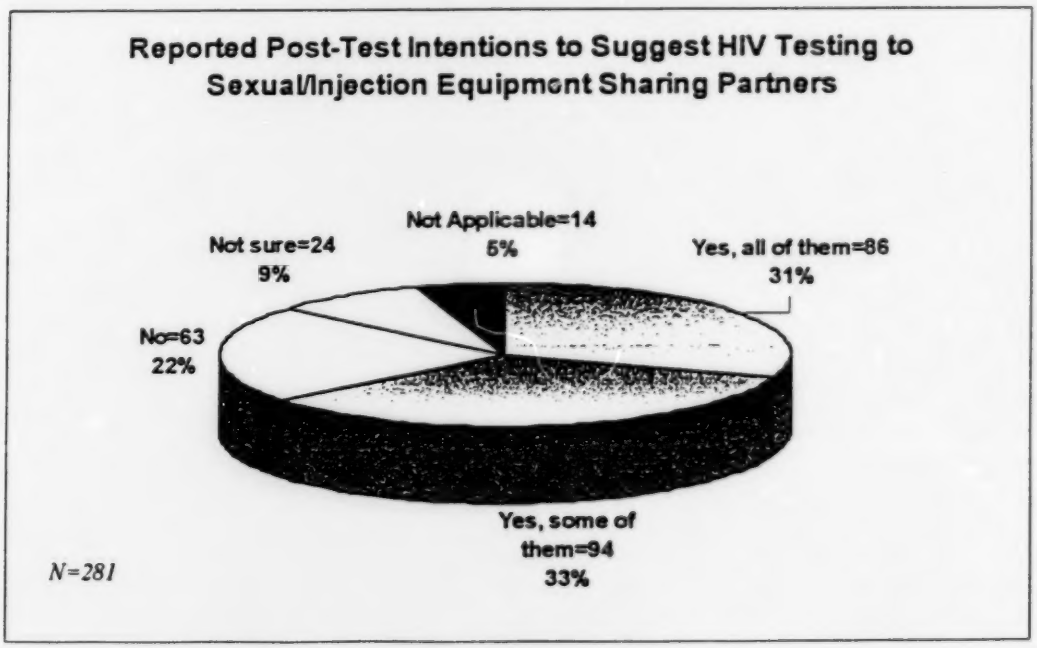


Figure 18



II. Client Feedback (N=310)

4.0 Helpfulness and Impact of Service

Figure 19

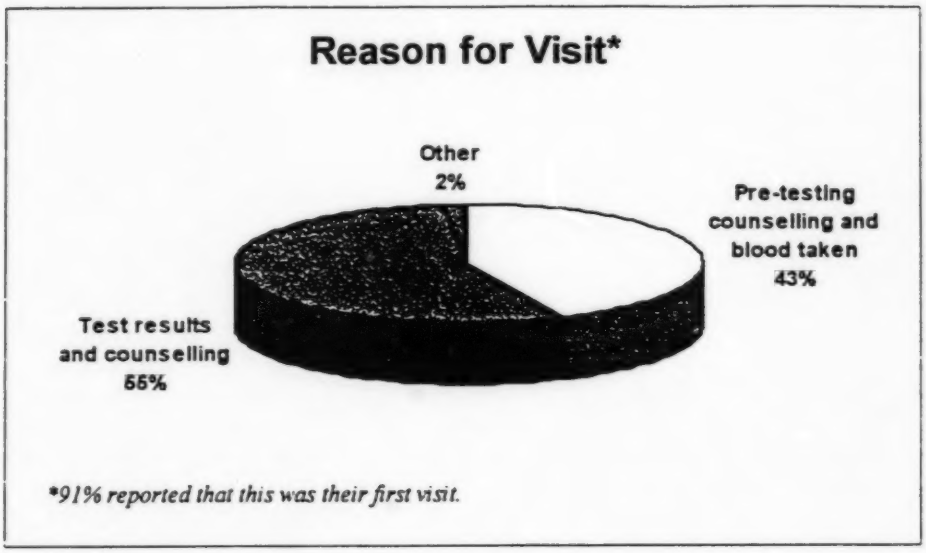


Figure 20

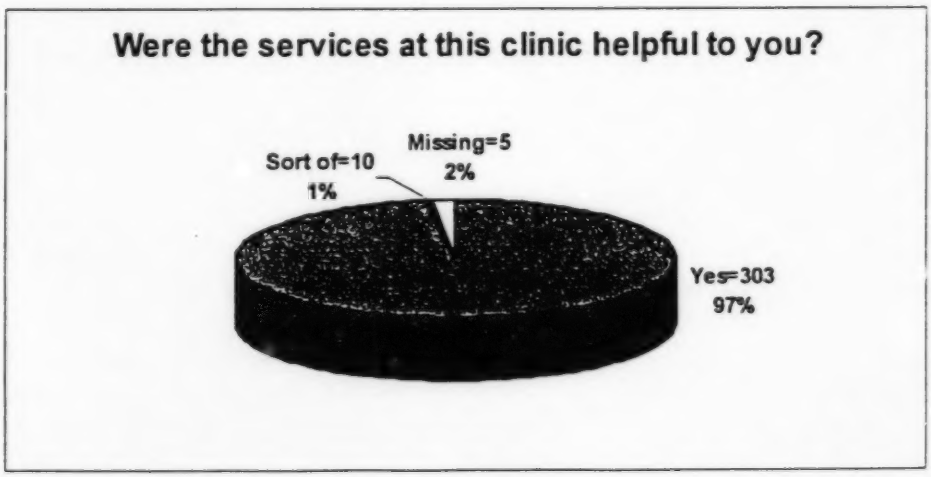


Table 6: Open-ended comments

Please explain (n=147)

1. Clarity and Relevance of Information Provided (42).

- All of my questions were answered clearly.
- All of the information.
- Answered all questions I had (very informative).
- Answered my questions.
- Because I had received conflicting information and I needed some answers from a professional.
- Bonne explications (informations)
- Bons conseils et informations pertinentes.
- Ca m'a permis de savoir qu j'étais négative et de comprendre vraiment ce que c'était le virus du sida etc.
- Ca m'a renseigné sur mes chances d'être atteinte du VIH.
- Car j'ai appris beaucoup de choses qui m'aiderons dans ma vie future.
- Everything regarding the procedure was very well explained.
- Everything was explained thoroughly.
- Everything was very informative; answered a lot of questions I was requiring.
- Excellent counselling and nurse.
- Excellent explanations.
- Explained what the test consisted of and the importance of the time lag from infection to detection.
- Good information about HIV and safe sex.
- I learned a lot of things I didn't know before.
- I received the HIV/AIDS testing I was looking for (because I am more conscious of the risks of unprotected sex).
- I was given information and pamphlets on HIV before testing and would definitely come back if I need to.
- Il y avait quelques points qui nétaient pas claire, que je ne savais pas.
- Ils mon tout expliquer ce que je ne savais pas sur la maladie.
- Ils m'ont éclairé sur le virus.
- It helped to make me more aware of the risk.
- M'as permis de mieux me renseigné sur le sida, ainsi que pour passer un test.
- Material related to the test and related matters were thoroughly covered by the counsellor The nurse was very friendly and helpful in giving me information and answering my questions.
- Oui car j'avais besoin de savoir des choses très importantes et ils étaient la pour les répondre.
- Parce que j'ai pu avoir l'information que je voulais.
- Parce qu'il explique en détail.
- Talking with me explaining the possibility of getting AIDS through a needlestick.
- They explained what was going to happen clearly.
- They helped me learn more about HIV/AIDS and I was really grateful for that information.
- They talked me through each step of the way and answered any questions I had
- To help explain all aspects of HIV testing.
- To talk with someone and receive the information on different agencies I can turn to should I test positive.
- Très bien expliqué. Très attentif à mes questions.
- Très heureuse du service and de la compréhension reçue.
- Understandable - "everything I wanted to hear."
- Very helpful - information re follow-up testing and other tests that should be done to ensure optimum health was very helpful.
- Very helpful in explaining how a "risk" exposes one to HIV/AIDS.
- Very informative and precise in answering all my questions.
- Very informative; lots of advice

2. Client Centered/User-friendly aspects (39)

- Able to feel comfortable and find out info that is needed.
- C'est confidential et les spécialiste très gentils.
- C'était rassurant et la madame était très gentille.
- Diane Lapointe (Public Health Nurse) was very friendly and very helpful.
- Elle a été franche avec moi et elle ne m'a trop stressés
- Everyone very supportive and encouraging.
- Explained things well. Friendly.
- Extremely. I got in for testing the day of my call. I was able to receive my results earlier than anticipated. This alleviates a lot of stress.
- Facile d'accès, anonyme, excellente réception et personnel, très compréhensif.
- Friendly; not rushed; things very well explained.
- Helped me with blood test - Nice people here.
- I felt they were very helpful and informative
- I felt very comfortable coming here, the nurse was very helpful and honest.
- I found it very informative. Diane Lapointe (the Public Health Nurse) was very nice
- Ils m'ont permi d'une façon simple les resultats que je recherchais.
- Ils m'ont rassuré et très bien conseilléé.
- Infirmière calme et aidante.
- Nurse offered to do other tests because there was extra time.
- Nurse was very knowledgeable, kind, understanding, helpful. I felt better after getting information.
- On explique beaucoup et on discute. L'infirmiere nous donne beaucoup de conseils.
- Parce que la garde malade est très sympathique.
- Parce que les infirmières étaient nice et j'ai pu savoir si j'avais une maladie ou non.
- Reassuring, knowledgeable; Diane went out of her way to help me.
- The lady was very kind and understanding and things went smooth.
- The nurse made me feel comfortable.
- The services here are very good. The workers are very nice.
- They give you lots of information and are very supportive.
- They offered information, were gentle and kind. Made you feel very comfortable.
- They were very helpful.
- Very direct and not intrusive
- Very friendly and cooperative. Gave very helpful information.
- Very friendly. Friendly, easy to talk to. I felt at ease.
- Very helpful - quick service.
- Very informative, understanding.
- Very nice, sympathetic.
- Very personable. Friendly, comfortable atmosphere.
- Very supportive.
- Very understanding counsellors who didn't judge me and were friendly towards me.
- Yes, I felt very comfortable and the counsellor was excellent and understanding.

3. Importance and Value of Service/Anonymity (26)

- Anonymous (X 4).
- Anonymous testing important because some people scared people will find out if names used.
- Ce sont des services qui sont essentiels même si ça me servis que pour rassurer
- C'est anonyme et très bien expliquer. Toute mes questions on été très bien répondu.
- C'est avantageux de pouvoir effectuer un test de VIH confidentiel.
- Gave me assurance that I was HIV-negative without anyone knowing about the test.
- Grâce aux services confidentiels, ca ma mise allaise.
- Having anonymous testing is a much needed service
- I always wanted to know if I was in contact with HIV, but was afraid to ask and wanted it to be anonymous.
- I just couldn't go to my doctor for this.
- I liked the anonymous aspect - plus the nurse was extremely approachable and kind.
- I liked the possibility of getting tested anonymously.

- I wanted secrecy.
- I would never have tested if I had to give my name (X2).
- Ils m'ont permis de subir un test de façon anonyme.
- Learned about means of transmission, will be relieved to get test results.
- L'entraide sans questions.
- Only way to get an anonymous test.
- Professional staff and an extremely valuable service.
- The anonymous aspect of the testing.
- Vous avez su comment nous mettre à l'aise et il est important que ce soit confidentiel.
- Yes, because it was confidential.

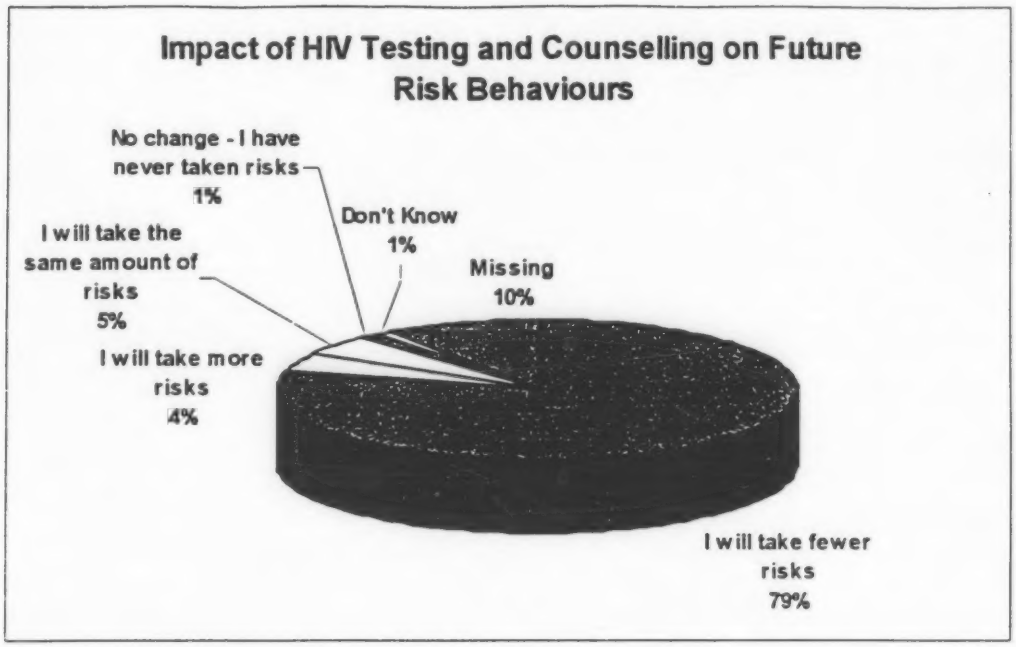
4. Importance of Knowing One's Status (16)

- Appaise la conscience "relief".
- Because I wanted to know.
- Car ça régler une petite peur (doute) que j'avais depuis un certain temps. Maintenant je suis très contente et soulagée..
- Gave me peace of mind.
- Gets rid of suspense, able to relax.
- I got to know whether I was negative or positive which is more safe for me and my partners.
- I had to know.
- I needed it to be sure!
- I was real scared I had AIDS.
- J'ai pu savoir si j'avais le VIH ou non.
- Je sais a présent que je suis négatif.
- Je serai sur de moi-même et de ma vie sexuelle.
- M'a aidé a me soulager de mon anxiété du virus du SIDA.
- Se sentir propre dans ma peau.
- To know the result.
- They were necessary for my peace of mind.

5. Miscellaneous (26)

- Because it's confidential and I'm more comfortable with girls (doctor).
- Bon service (X 2).
- Elle mon permi de m'informer sur le VIH, tout en vérifiant si j'en suis atteint.
- Excellent!
- Helped me realize the high percent of risk we could actually have.
- I don't have a doctor.
- I don't have a family doctor and I want the tests.
- I have a lot of risks.
- I have been tested before but was brought up to date.
- I knew what was already explained to me [client saying the service was "sort of" helpful].
- I obtained the service I was looking for.
- Ils m'ont faites senser à prendre moins de risques.
- It helped me deal with some of life's ups and downs.
- It is very local to people who need it.
- Les intérvenantes ont une bonne formation et font bien leur travail.
- Mais, plus de test anonymes pour différentes MTS.
- More enlightening.
- My doctor wouldn't test me.
- Nécessite une preuve de VIH négatif pour voyager dans certains pays.
- Referred by my doctor.
- Renseignements sur SIDA.
- This clinic is great.
- Verified to girlfriend a negative test.
- Very good service.
- Very helpful to my mental state of dealing with problems. I made a new friend Maria.

Figure 21


Impact of HIV Testing and Counselling on Future Risk Behaviours
No change - I have never taken risks 1%
Don't Know 1%
Missing 10%
I will take the same amount of risks 5%
I will take more risks 4%
I will take fewer risks 79%

5.0 Relevance of Anonymity

Figure 22

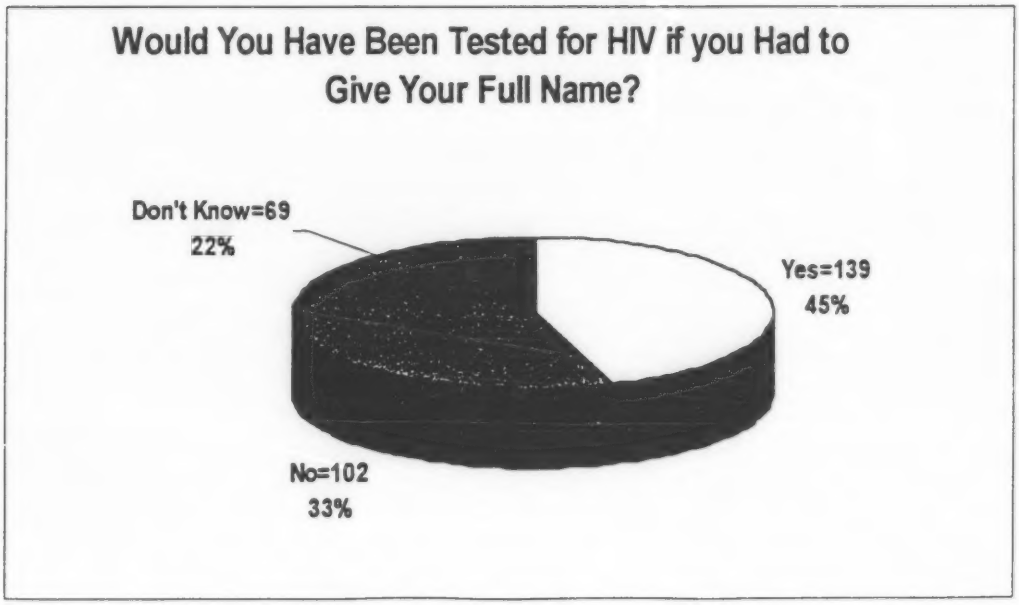
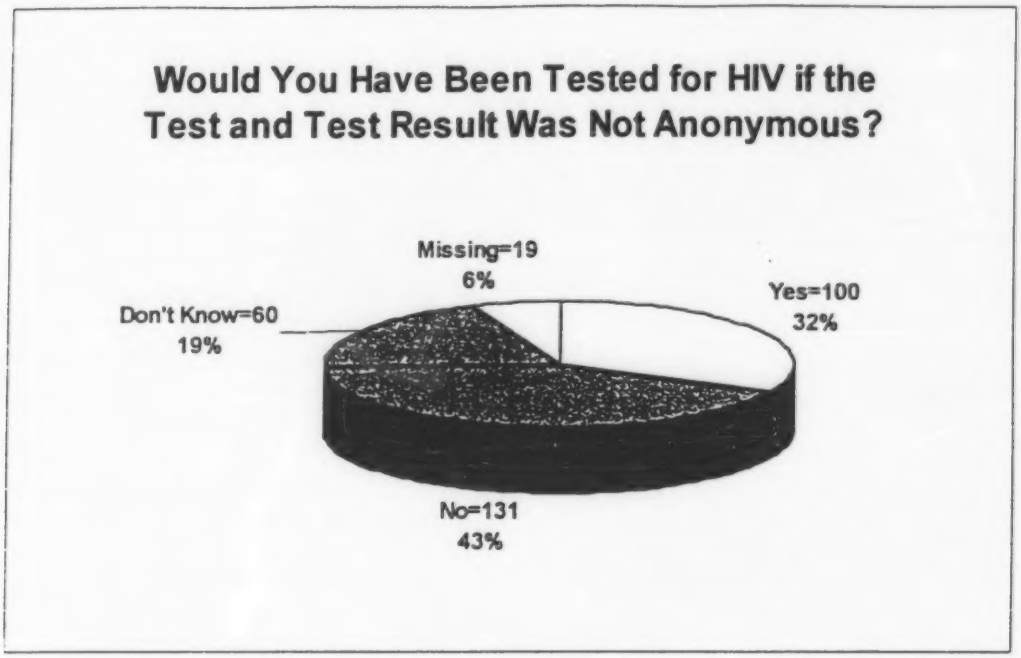


Figure 23


Would You Have Been Tested for HIV if the Test and Test Result Was Not Anonymous?
Missing=19
6%
Yes=100
32%
Don't Know=60
19%
No=131
43%

6.0 Additional Comments

Comments (n=147)

Importance and Value of Service/Anonymity (26)

- An important service for individuals and Public Health.
- Anonymous testing is imperative - not very many people will risk the fact of their being tested getting made public.
- Anonymous testing makes you more liable to be tested than having to go to doctor and having a permanent record, before you know the results.
- Appreciate anonymity.
- Ce projet pilote dôit être accessible à tous, surtout pour les gens inquiets que leur état de santé devienne connu de gens "non-pertinent".
- C'est un service bien utile qui permet les gens de se fair 'tester" dans l'anonymat si le besoin est ressenti et c'est bon.
- C'est un service nécessaire pour diminuer le % d'augmentation du virus VIH!
- Confidentiality is important and it is obvious.
- Excellent ressource humaine.
- I feel this procedure and form of testing is an excellent idea. My privacy is protected and that is important
- I feel this service is very necessary province-wide.
- I think it's a great program.
- I think that the Anonymous Testing is a great idea. I hope it will continue and be part of more places for blood testing.
- I would recommend the anonymous testing to others; in fact I have already told some of my friends and family.
- If someone wants anonymous testing, this is the way to go.
- In my opinion, I think anonymous testing should be a part of our health care.
- Keep this service available for people (the anonymous).
- Service utile et important.
- Thank-you. Anonymous testing is essential.
- The anonymous testing program should continue.
- The public deserves to have these tests done anonymously.
- This is a very good service that needs to stay in the community in order to help youth and young adults.
- This is a very valuable service!
- This project is a great idea and I believe it will benefit many people.
- This should have always been anonymous.
- Très important program de santé communautaire qui améliore la qualité de vie.

Client Centered/User-friendly aspects (18)

- Easy to talk.
- Felt comfortable.
- I think counsellor was very helpful, and made me feel very at ease.
- I thought the nurses were great and very supportive as well as open minded.
- J'aime la confidentialité de ce programme. Également la clinique est bien situé à l'égard des regards.
- Je connais depuis plusieurs années l'infirmière de la clinique. Elle ne me juge pas et donne toujours encouragement a changer et mieux faire.
- Je suis très comfortable a venir à votre clinic. Vous êtes très professionnel et on se sent à l'aise.
- La garde malade est fine avec moi.
- Ma visit fut positive et rassurante.
- Service was great. Reference material was provided to me at the time of my testing.
- Thank you for making this process easier for me. I felt at ease with your nurse.
- The nurse that I talked to was very friendly and understanding; I felt very comfortable.
- The service was incredibly helpful and supportive. I would recommend this clinic to anyone.
- The test was fast and easy. It was very comfortable.
- They are nice here.
- They were real nice here. I was scared and I had a bad feeling. Now I'm so happy I'm ok.
- This is a very comfortable and non-threatening environment to have the test done.
- Tout est claire et parfait.

Impact on Knowledge/Behaviours (10)

- I will take no risks. The anonymous testing is a very good idea for many people.
- I didn't know I should use a condom for oral sex.
- Learned a lot of things, and ways to take precautions to protect myself and others.
- Avant que j'ai encore une relation sexualle, je vais envoyer mon partenaire se faire vérifier. Merci!
- Hope to main risk free.
- I feel safer now and plan to be safer.
- I know now... so I hope I don't have to call you again.
- I was not as careful as I should be- I will be now.
- I will take no risks.
- Now realize how important it is to practice safer sex. Very nervous!

Specific Suggestions (27)

- All tests should be provided at once.
- An effort to increase the public awareness of this program would be beneficial to the community and society as a whole.
- Be able to be tested anonymously for Hepatitis B and anything else that would make people feel more comfortable.
- Clinic is a good idea and should continue to be published more so that more people are aware that anonymous testing is available.
- Could the other tests be anonymous? (Hepatitis B & C, syphilis). Could this be available 5 days a week?
- Hepatitis B & C testing would be desirable.
- I am very glad that this service is available, and I hope it keeps on for many years to come, for everyone.
- I believe that other tests should be done for other diseases other than HIV, with the same blood samples given.
- I believe the reason a lot of women especially don't ask their doctors to test them is because their doctors tend to believe that women are just the nervous type. Hepatitis B & C should also be available in clinics like these.
- I would have liked to have been tested for Hepatitis at the same time.
- I would strongly support a decision to include Hepatitis testing within such a program.
- It would be nice if I could have been tested for Hep B & C at the same time.
- J'aimerais que ces services continue. Merci.
- J'aimerais que vous fassiez plus ou d'autres test du MTS.
- Keep this service available. Make it more known. AIDS NB is not easy to find in phone book - it goes with acronyms
- La période d'attente était longue. Je me suis tenu occupé et ça bien été.
- Lors de la reponse, au lieu d'un medecin qui assisterait aux verdict positif, un travailleur sociale ou un psychologue serais beaucoup plus appreciee.
- Make all tests anonymous.
- Tests for all STD's should be done the same way as the anonymous HIV test... for all age groups and sexes.
- The Sexual Health Centre needs to be listed in the phone book. More awareness for those in need.
- The waiting period of test results was hard. Your mind has a lot of time to think. Maybe a shorter time frame.
- This is a valuable service, should be advertised.
- Very awkward and confusing signage. No map. Why is the Country Hall of Fame where it is?
- We also need to be able to be tested for Hepatitis B and C.
- Why can I get HIV testing anonymous but can't get Hepatitis and Syphilis tests anonymously? That just isn't right
- Why is this place so hard to find? The signs don't help.
- Would like them to have pharmacies and doctor more knowledgeable about sexual diseases.

General Thanks/Satisfaction/Gratitude (28)

- Ça fait longtemps que je connais le Centre et est satisfaite des services
- I am relieved and I am very grateful.
- I am very happy for negative results.
- I am very satisfied with the work of the Sexual Health Clinic.
- I think this is a very good program.
- I'm glad that such a service is available to the young public. It's about time!
- I'm glad this program exists.
- J'ai apprécié la façon don't elle m'a informé de tout.
- J'aime le système.
- J'aimerais remercier tous ceux et celles qui ont pris part dans la réalisation de ce projet. Cette maladie finira par être un obstacle franchit pour l'humanité grâce à vos efforts moraux et professionels.
- Je trouve la façon de proceder très adequate.
- Je trouve que c'est très bien d'avoir un centre comme celui-ci consacré au dépistage de MTS et du VIH/SIDA.
- Je trouve que c'est une bonne idée. Ça fait du bien en parler.
- Keep up the good work!
- Merci pour m'avoir écouté. Ça été très apréciée!! Continue ton bon travil. J'espère que tu pourras aider d'autres jeunes dans ma situation et ils t'appréciront tant que je t'ai apprécié. Maintenant je sais que j'ai faite la bonne décision de venir ici.
- Non, merci pour tout.
- Service Excellent.
- Thank you (X 3).
- Thank you for your help-support and being there anonymously.
- The anonymous test is comforting because this is a very personal issue. Thank-you.
- Très bon service.
- Très satisfaite des services offerts.
- Très satisfaite.
- Vous êtes super.
- Vous êtes super. Merci.

Miscellaneous (12)

- Better safe than sorry.
- Ça fait longtemps que je ne prends plus de risque. Satisfait.
- Good Bye.
- Hoping you continue the Anonymous HIV Testing.
- I already have a high level of knowledge regarding HIV *[client saying the service was "sort of" helpful]*.
- Merci de votre aide et je vous rendré la pareille dès aujourd'hui et jusqu'au bout. Que Dieu nous pardonne et nous aides tous.
- More comfortable in my current sexual relationship with a woman who has also tested negative.
- Never taken any sexual risks. Am a middle-aged virgin who was raped.
- Please hurry with the results.
- That having a test result saying negative feels great.
- To keep up the good work.
- What should a person do if he/she has been sexually assaulted?